Connecticut SIM: Creating a Culture of Value

Medical Assistance Program Oversight Council

Women's Health Subcommittee

December 7, 2015

Agenda

1. What is the State Innovation Model Initiative?
2. What are the components of CT's SIM?
3. What problems are we trying to address?
4. What care delivery reforms are we promoting?
5. Value-based Payment Reform
6. Quality Measure Alignment

What is a State Innovation Model Grant?

SIM grants are awarded by the federal government through the ***Center for Medicaid and Medicare Services (CMS) Innovation center***. Grants are awarded to states that have demonstrated a commitment to developing and implementing multi-payer health care payment and service delivery models that will:

1. Improve health system performance
2. Increase quality of care
3. Decrease Costs

Connecticut awarded a $45 million test grant in December 2014 which will be implemented over the next five years.

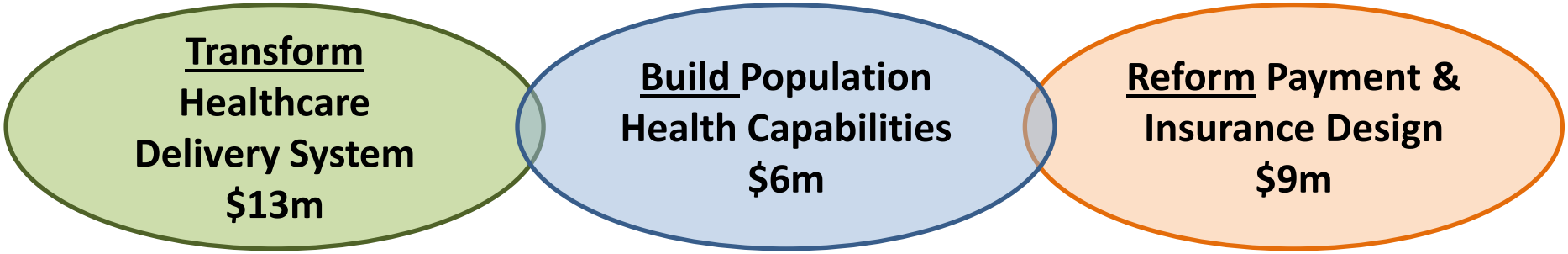
Vision

Establish a whole-person-centered healthcare system that:

- improves population health;
- eliminates health inequities;
- ensures superior access, quality, and care experience;
- empowers individuals to actively participate in their healthcare; and
- improves affordability by reducing healthcare costs

Our Journey from Current to Future: Components

CT SIM Component Areas of Activity



Transform the healthcare delivery system to make it more coordinated, integrate clinical and community services, and distribute services locally in an accessible way.

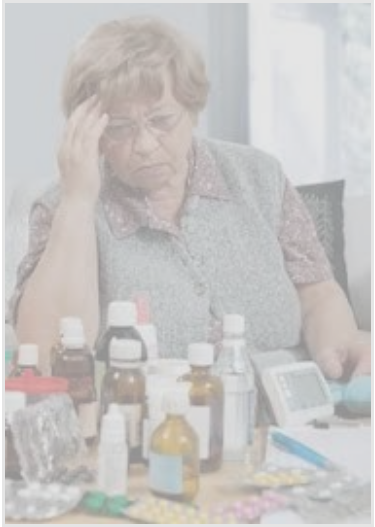
Build population health capabilities that reorient the healthcare toward a focus on the wellness of the whole person and of the community

Reform payment & insurance design to incent value over volume, engage consumers, and drive investment in community wellness.

Engage Connecticut's consumers throughout	**$376k**
Invest in enabling health IT infrastructure	**$10.7m**
Evaluate the results, learn, and adjust	**$2.7m**

Healthcare today – 1.0

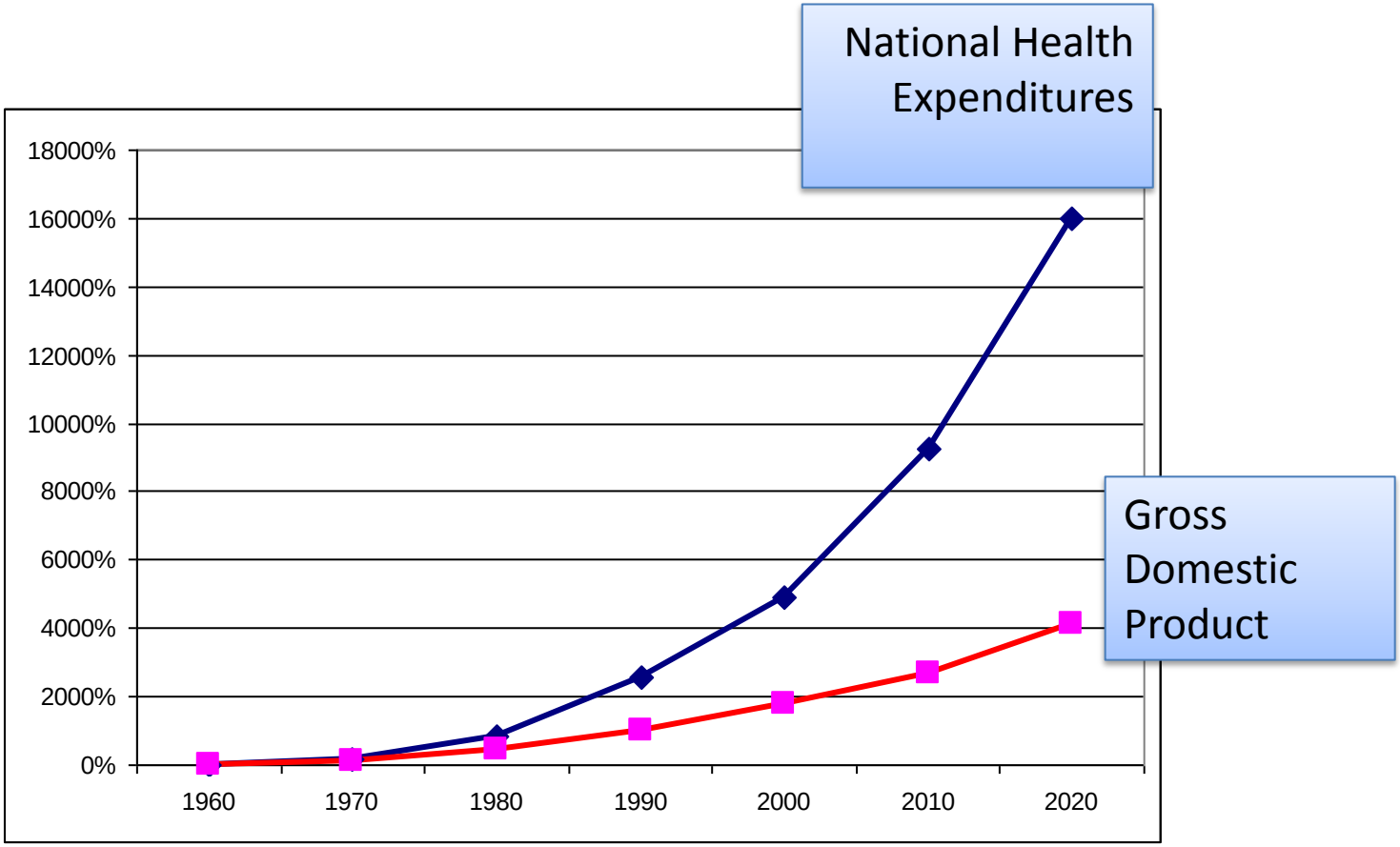
Connecticut's Current Health System: "As Is"



Fee For Service Healthcare 1.0

- **Limited accountability**
- **Poorly coordinated**
- **Pays for quantity without regard to quality**
- **Uneven quality and health inequities**
- **Limited data infrastructure**
- **Unsustainable growth in costs**

Healthcare Spending has Outpaced Economic Growth

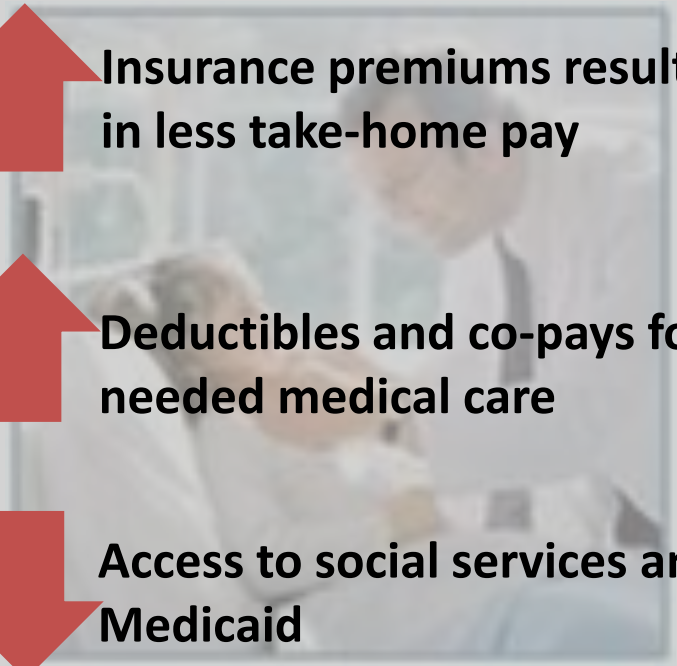


Source: CMS, National Health Expenditure Data

Escalating costs mean…

….patients will experience

- ↑ Insurance premiums resulting in less take-home pay
- ↑ Deductibles and co-pays for needed medical care
- ↓ Access to social services and Medicaid



….communities will experience

- ↓ Money for programs that support housing, education, the environment, and community development

Escalating costs mean…

….the **business community** will experience

US = Lowest Ranking for Safety, Coordination, Efficiency, Health

Exhibit ES-1. Overall Ranking

Country Rankings	
	1.00–2.33
	2.34–4.66
	4.67–7.00

	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,588	$3,837*	$2,454	$2,992	$7,290

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

Commonwealth Fund: http://www.commonwealthfund.org/publications/press-releases/2010/jun/us-ranks-last-among-seven-countries

How about Connecticut?

Connecticut Healthcare Costs

Connecticut *- healthcare spending = More than $30 billion,* ***fourth highest of all states*** *for healthcare spending per capita*

CMS (2011) Health Spending by State of Residence, 1991-2009.
http://www.cms.gov/mmrr/Downloads/MMRR2011_001_04_A03-.pdf

Connecticut: Uneven Quality of Care

Rising rate of Emergency Department utilization

Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries	2011	195	183	129	40

CT ranking out of 50 states

High Hospital Readmissions

Medicare 30-day hospital readmissions, rate per 1,000 beneficiaries	2012	52.0	45	26	36

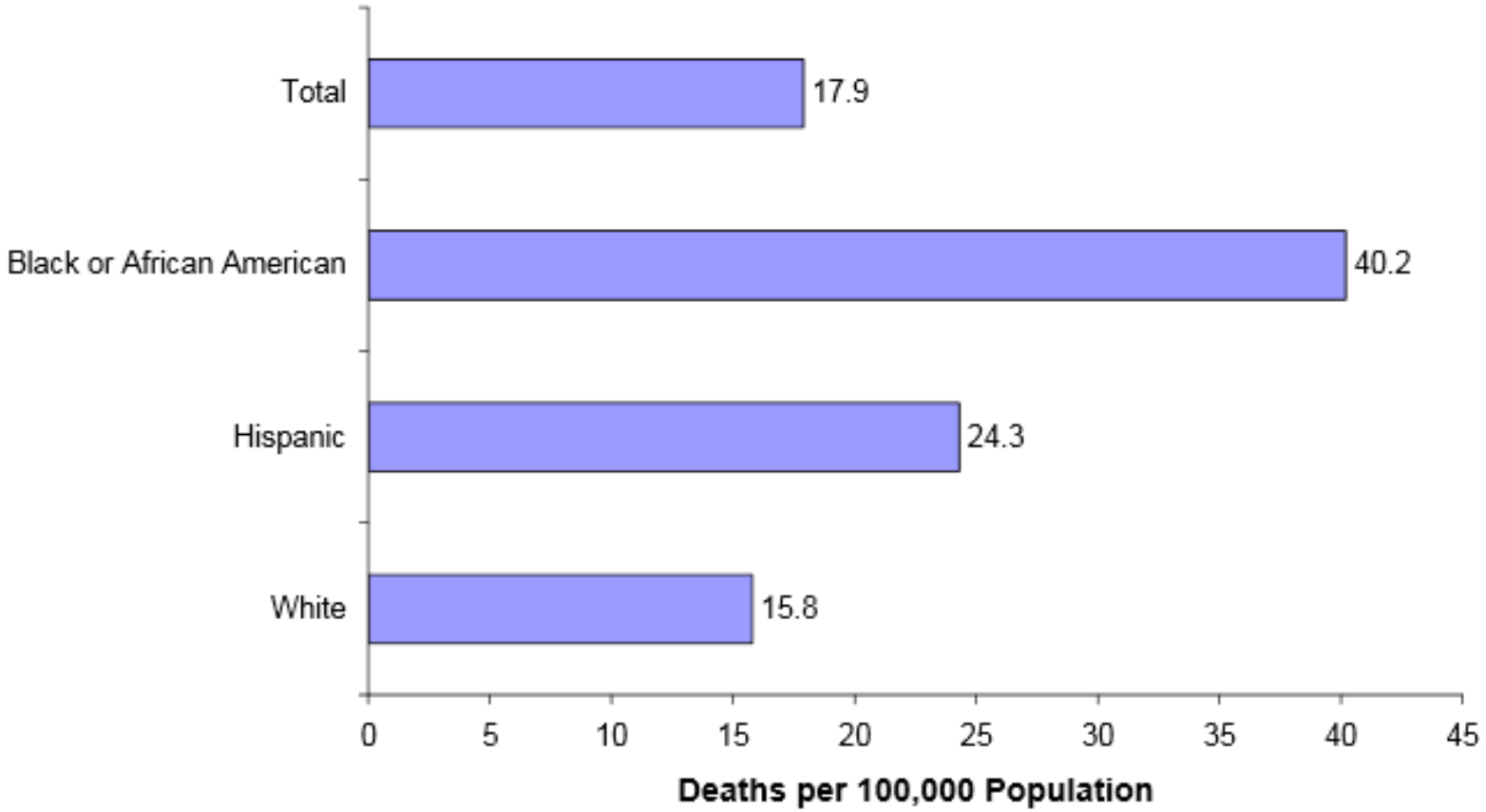
CT ranks 36th out of 50 states

D.C. Radley, D. McCarthy, J.A. Lippa, S.L. Hayes, and C. Schoen, Results from a Scorecard on State Health System Performance, 2014, The Commonwealth Fund, April 2014.

Health disparities persist in Connecticut

Diabetes Death Rates - Race/Ethnicity

Figure 7. Age-adjusted Death Rates for Diabetes, Connecticut Residents, by Race or Ethnicity, 2000–2004



Source: DPH 2008b, 2008v.

Health disparities persist in Connecticut

Health disparities devastate individuals, families and communities, and are *costly*:

- **The cost of the disparity for the Black population in Connecticut is between $550 million - $650 million a year**

Source: LaVeist, Gaskin & Richard (2009). The Economic Burden of Health Inequalities in the US. The Joint Center for Political & Economic Studies. As reported by DPH

Stages of Transformation

Stages of Transformation

Connecticut's Current Health System: "As Is"

Our Vision for the Future: "To Be"

Fee for Service 1.0

Limited accountability

Pays for quantity without regard to quality

Lack of transparency

Unnecessary or avoidable care

Limited data infrastructure

Health inequities

Unsustainable growth in costs

Accountable Care 2.0

Accountable for patient population

Rewards
- better healthcare outcomes
- preventive care processes
- lower cost of healthcare

Competition on healthcare outcomes, experience & cost

Coordination of care across the medical neighborhood

Community integration to address social & environmental factors that affect outcomes

Health Enhancement Communities 3.0

Accountable for all community members

Rewards
- prevention outcomes
- lower cost of healthcare & the cost of poor health

Cooperation to reduce risk and improve health

Shared governance including ACOs, employers, non-profits, schools, health departments and municipalities

Community initiatives to address social-demographic factors that affect health

Getting to…

Accountable Care 2.0

Targeted Initiatives

Statewide Initiatives

Model Test Hypothesis for SIM Targeted Initiatives

High percentage of patients in value-based payment arrangements

MQISSP
Medicare SSP
Commercial SSP

+

+

Resources to develop advanced primary care and organization-wide capabilities

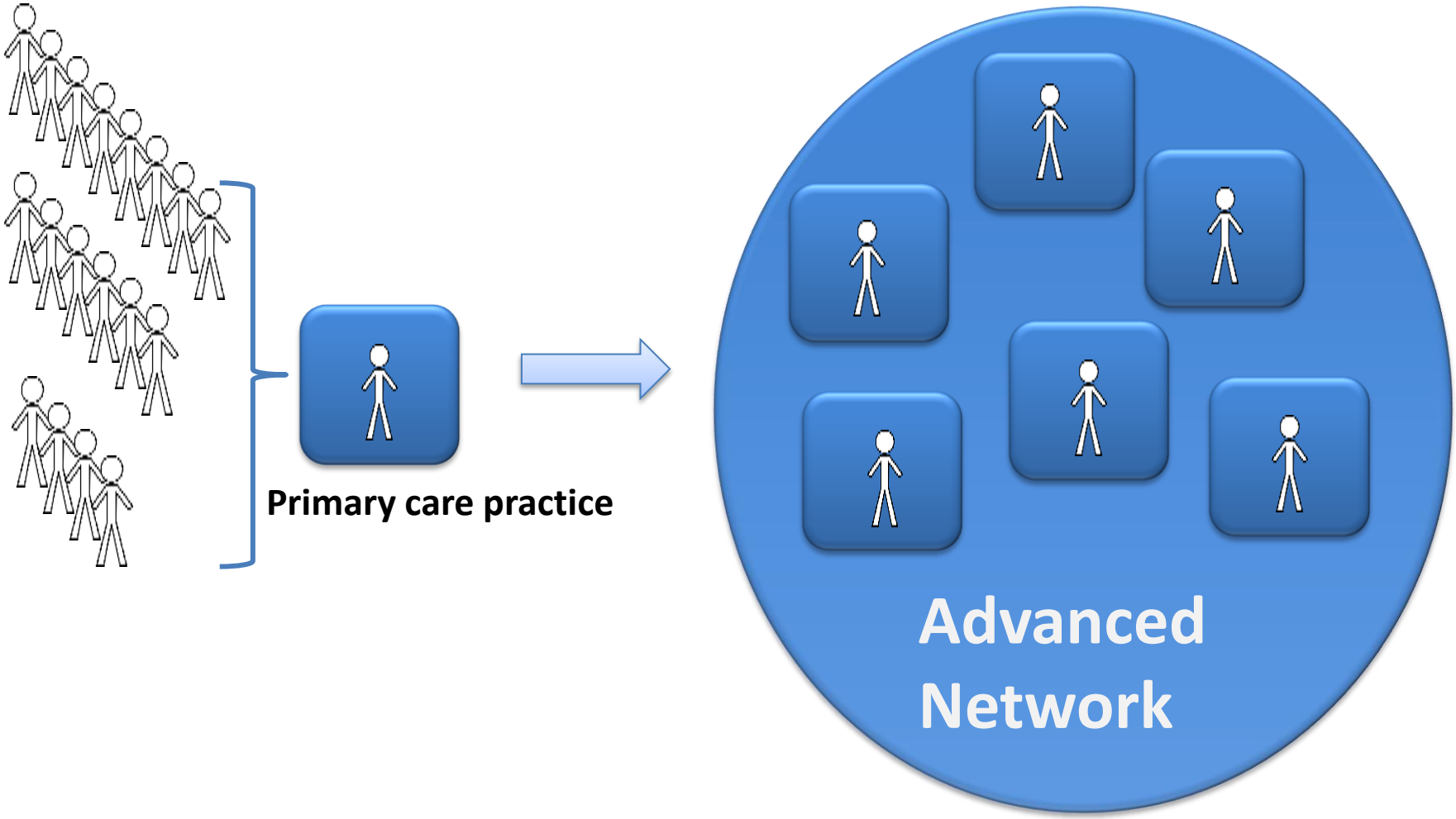
- Advanced Medical Home Program
&
- Community & Clinical Integration Program (CCIP)

=

Accelerate improvement on population health goals of better quality and affordability

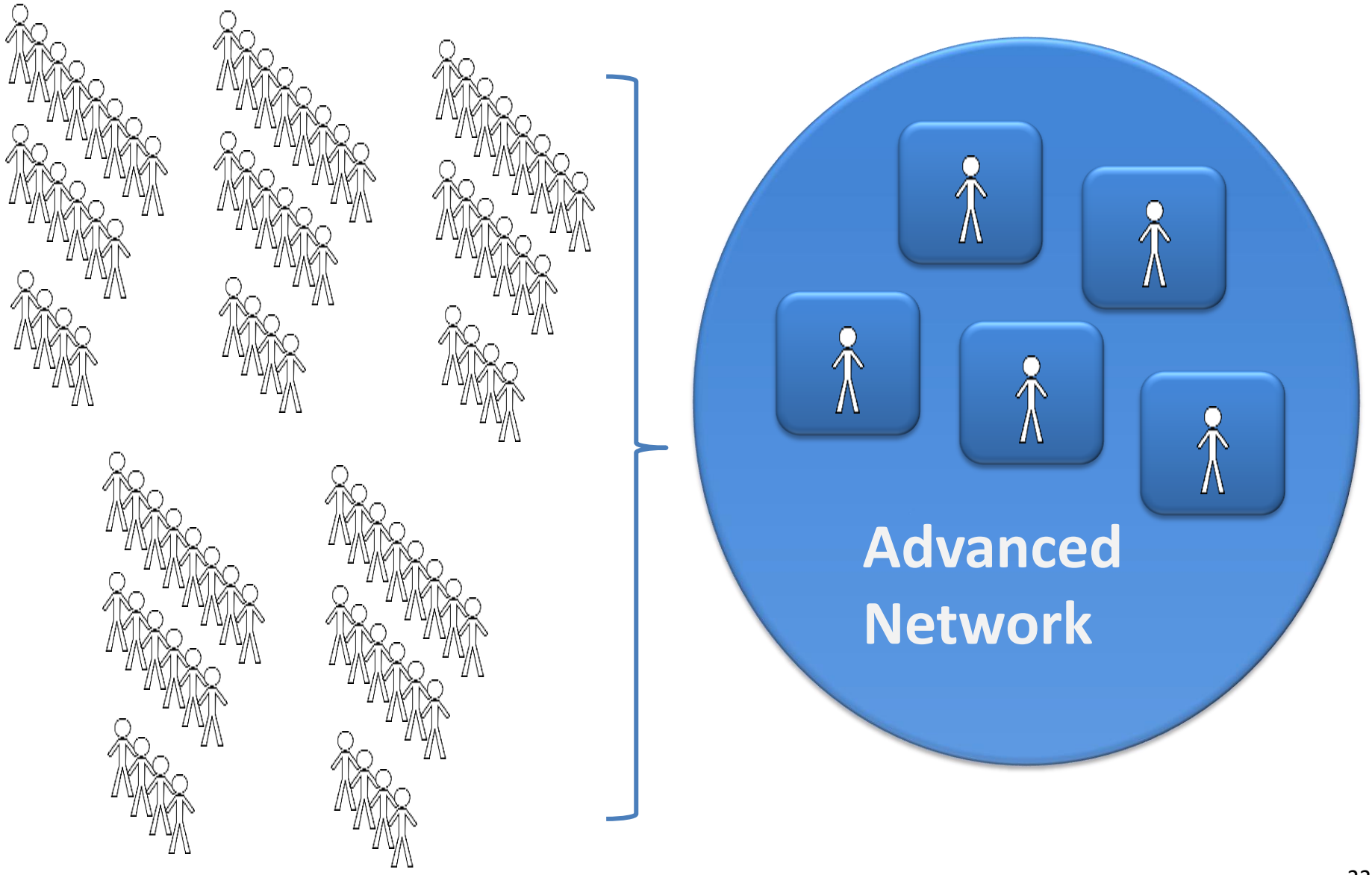
MQISSP is the Medicaid Quality Improvement and Shared Savings Program

Primary care partnerships for accountability

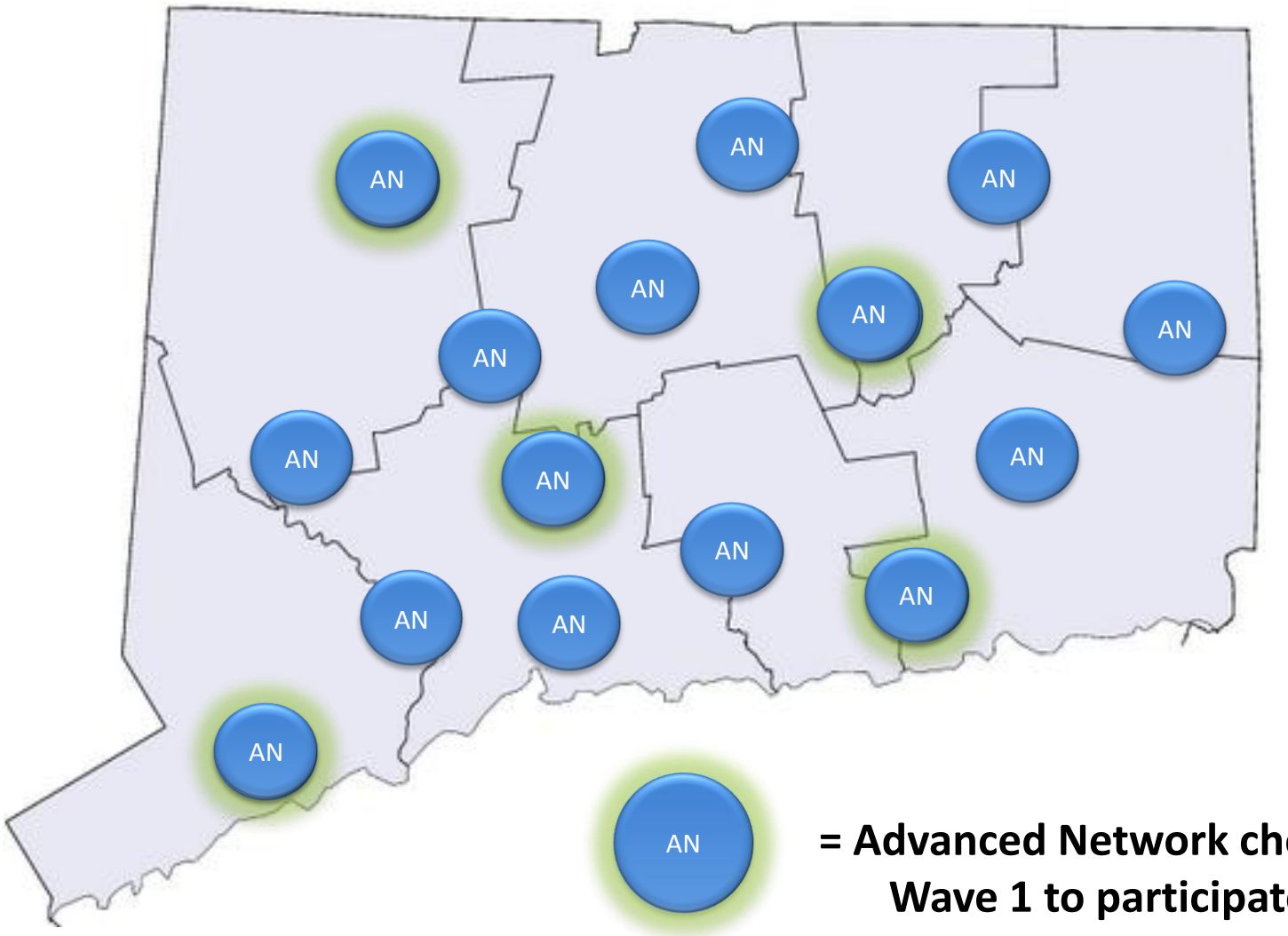


Advanced Network = independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer

Accountability for quality and total cost

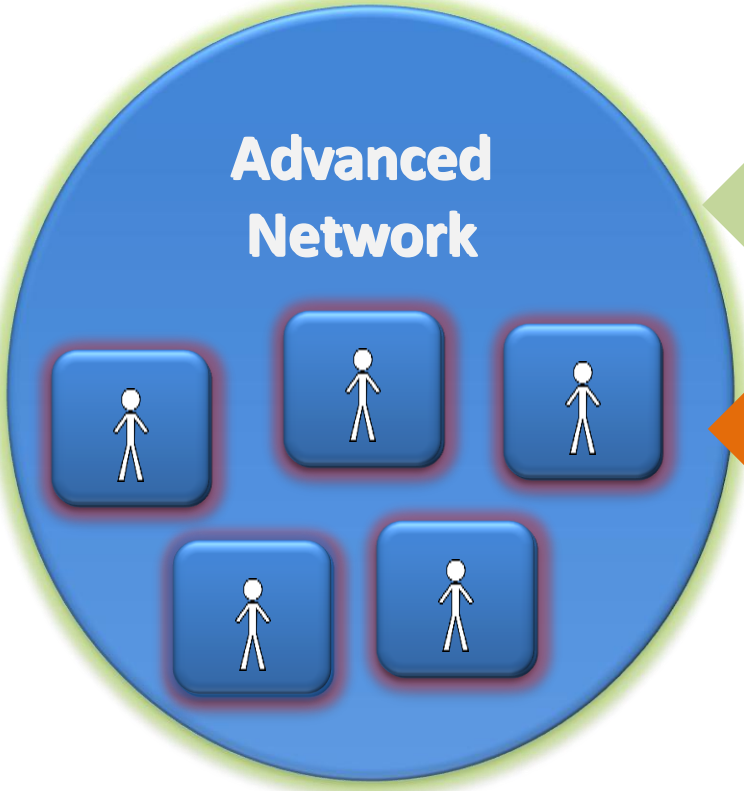


Connecticut has many Advanced Networks



= Advanced Network chosen in Wave 1 to participate in Medicaid Quality Improvement & Shared Savings Program (MQISSP)

Resources aligned to support transformation



Community & Clinical Integration Program (CCIP)

Awards & technical assistance to support Advanced Networks in enhancing their capabilities across the network

Advanced Medical Home (AMH) Program

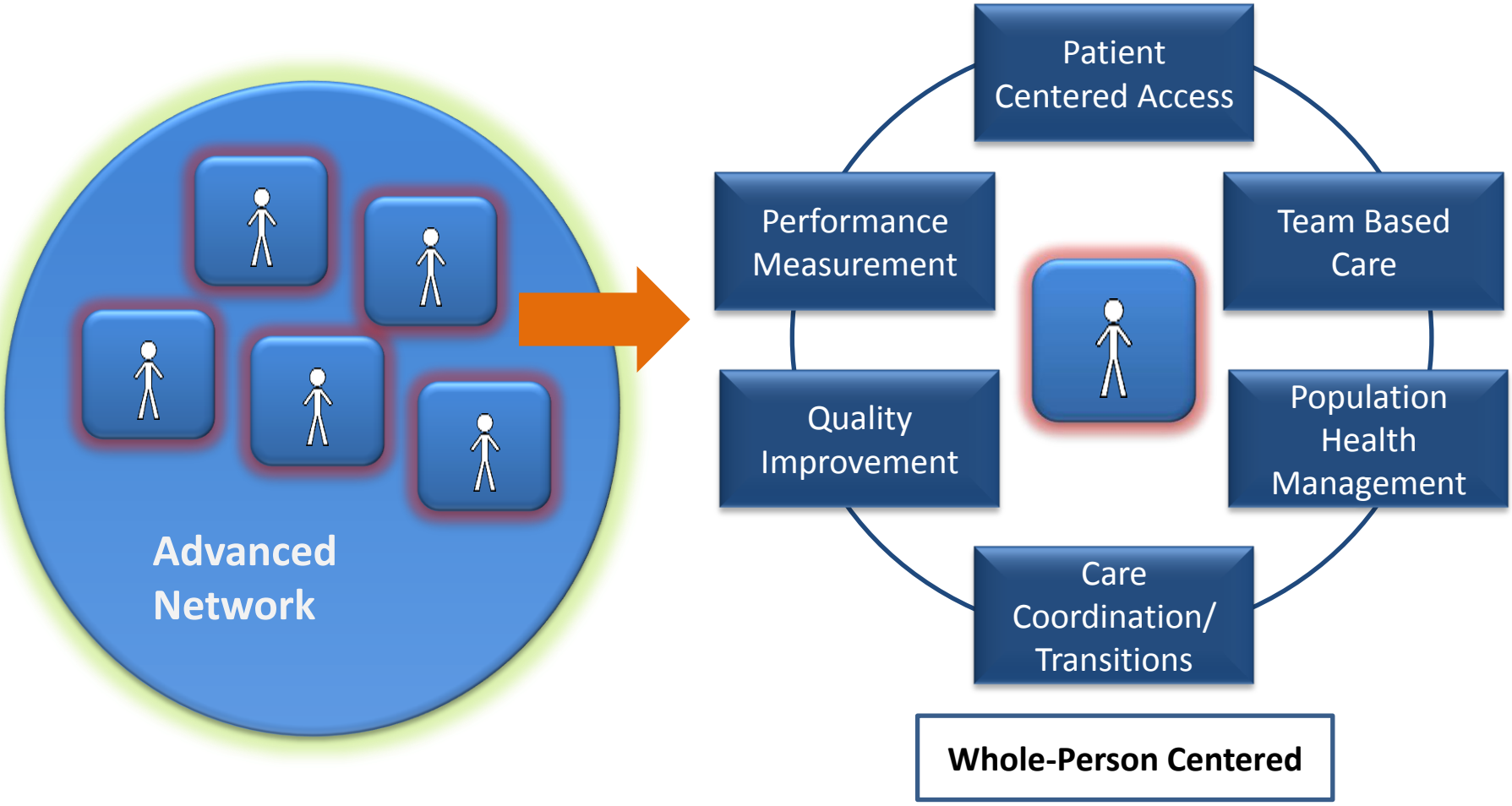
Support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 recognition and additional requirements

Improving care for <u>all</u> populations
Using population health strategies

Improving capabilities of practices in Advanced Networks

Advanced Medical Home Program

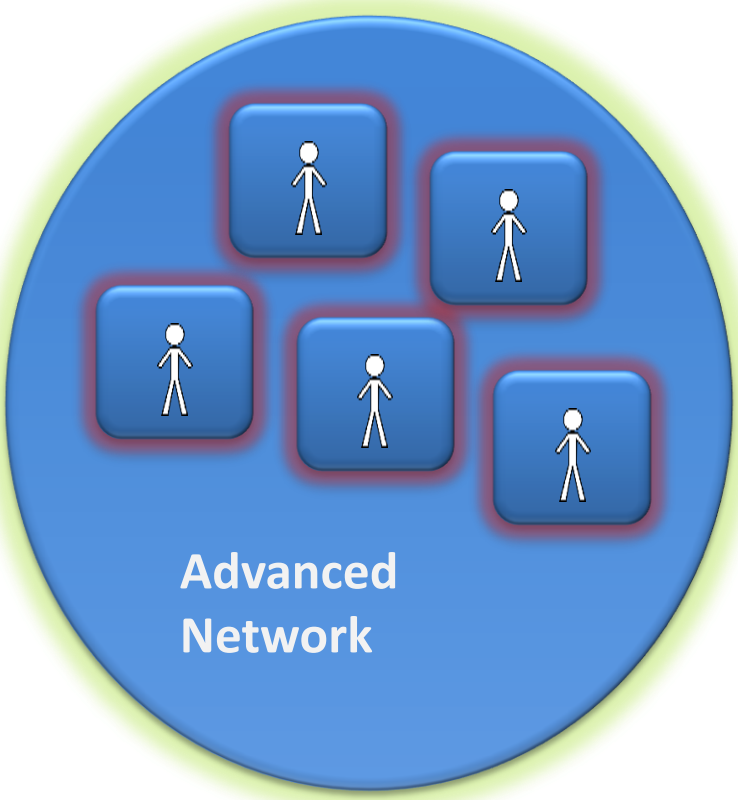
Webinars, peer learning & on-site support for individual primary care practices to achieve Patient Centered Medical Home NCQA 2014 and more



Improving capabilities of Advanced Networks

Community & Clinical Integration Program

Awards & technical assistance to support Advanced Networks in enhancing their capabilities in the following areas:



Supporting Individuals with Complex Needs

Comprehensive care team, Community Health Worker , Community linkages

Reducing Health Equity Gaps

Analyze gaps & implement custom intervention ✚ **CHW & culturally tuned materials**

Integrating Behavioral Health

Network wide screening, assessment, treatment/referral, coordination, & follow-up

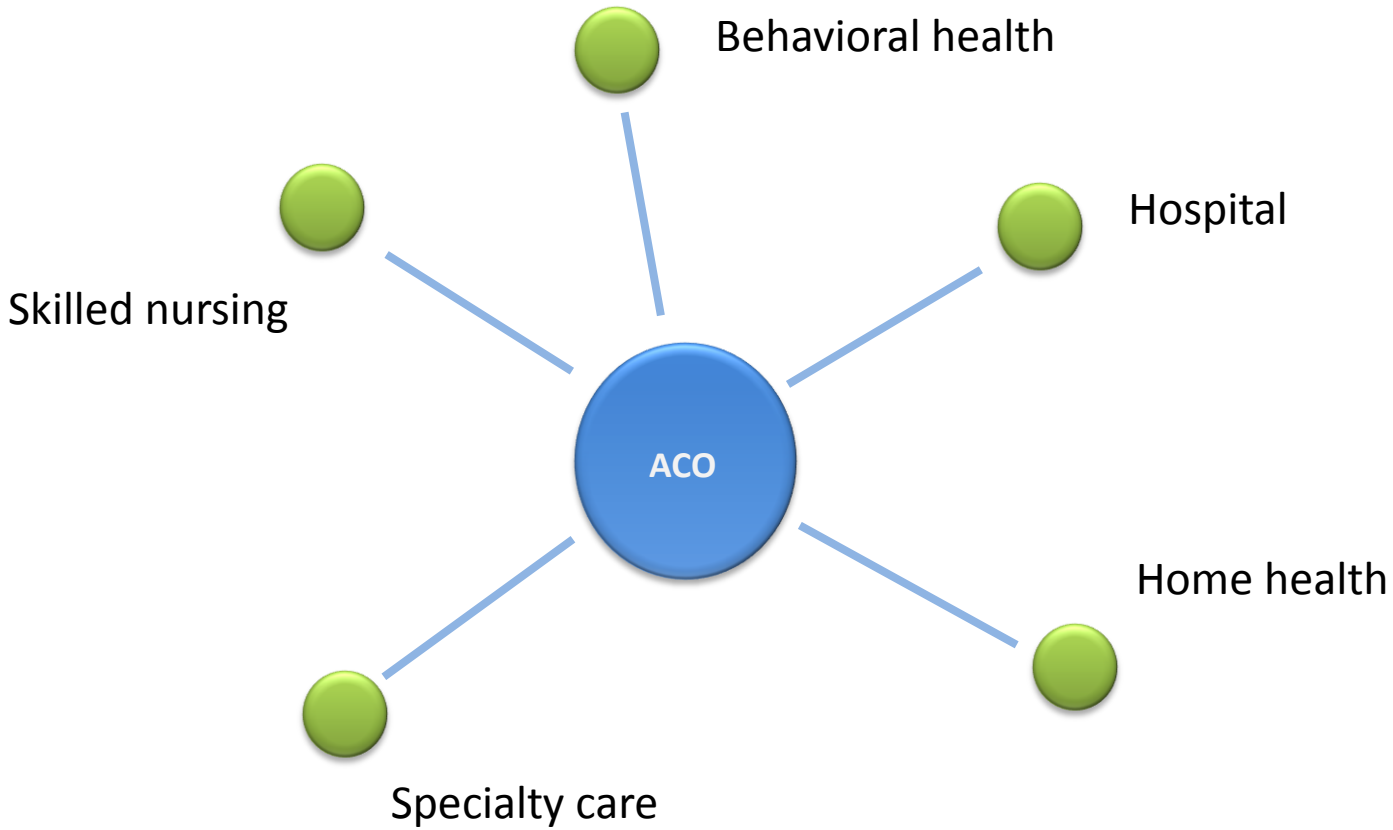
Community Health Collaboratives

Comprehensive Medication Management

E-Consults

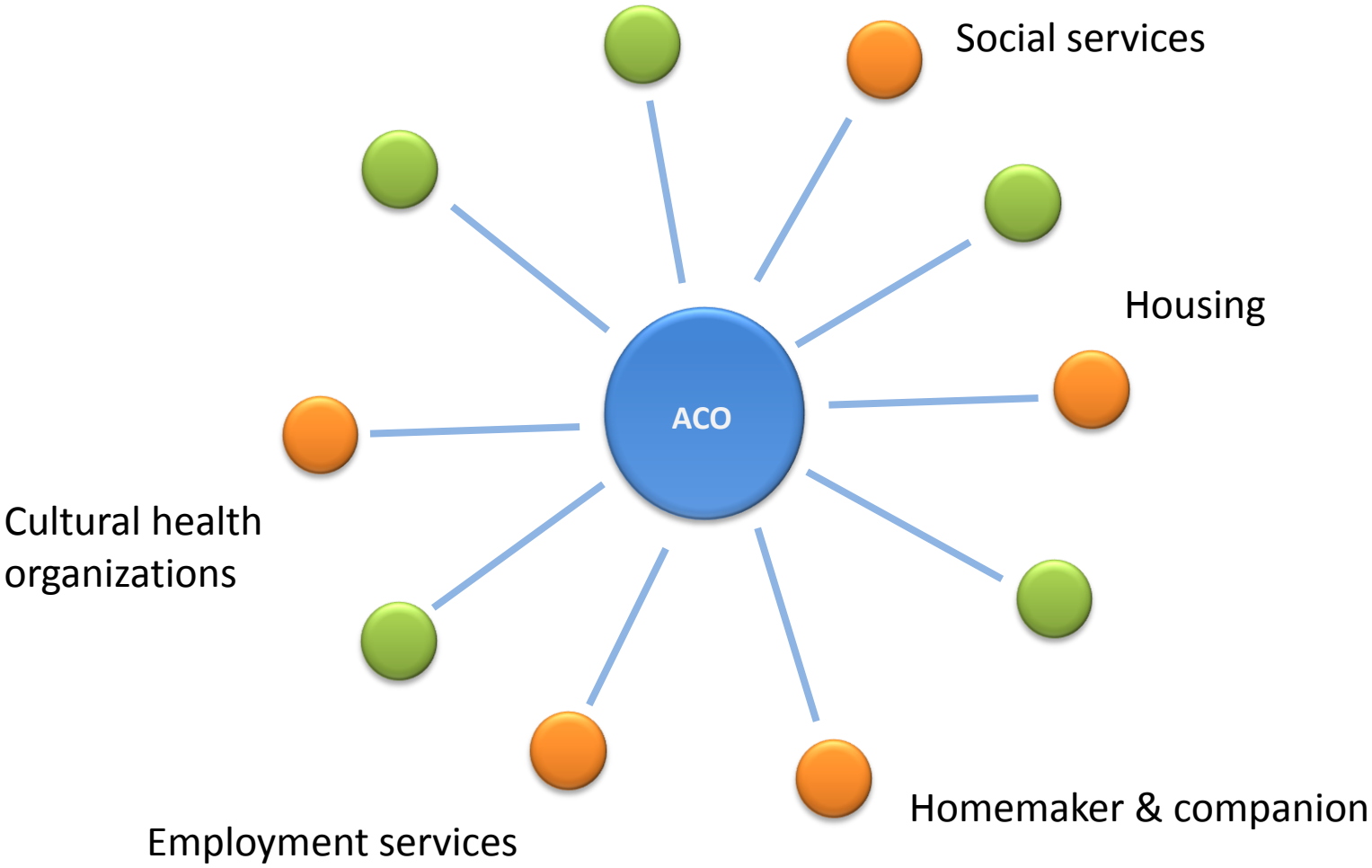
Oral health

New capabilities will emphasize….



…clinical integration and communication across the medical neighborhood

New capabilities will also support…

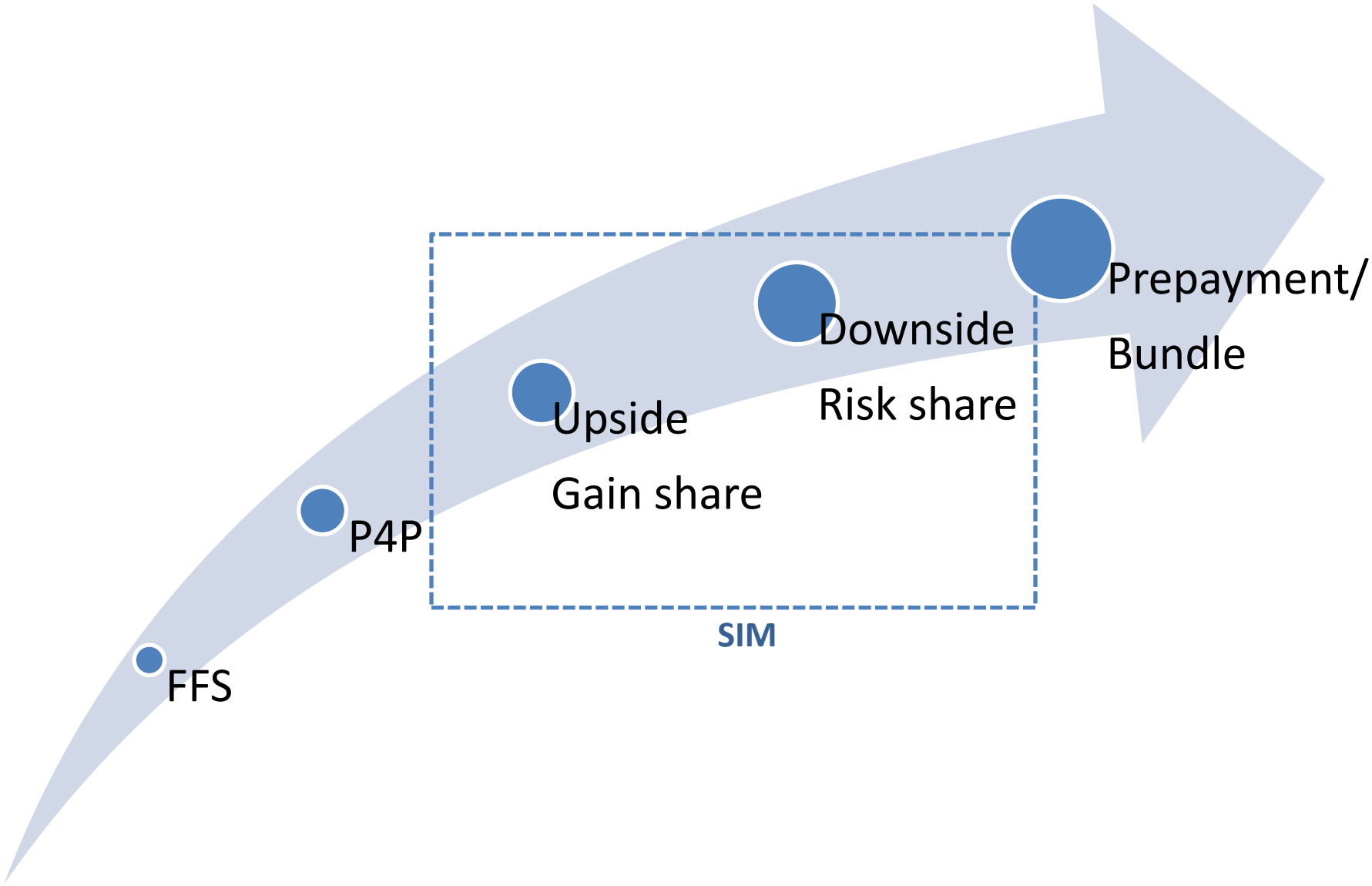


…coordination and integration with key community partners

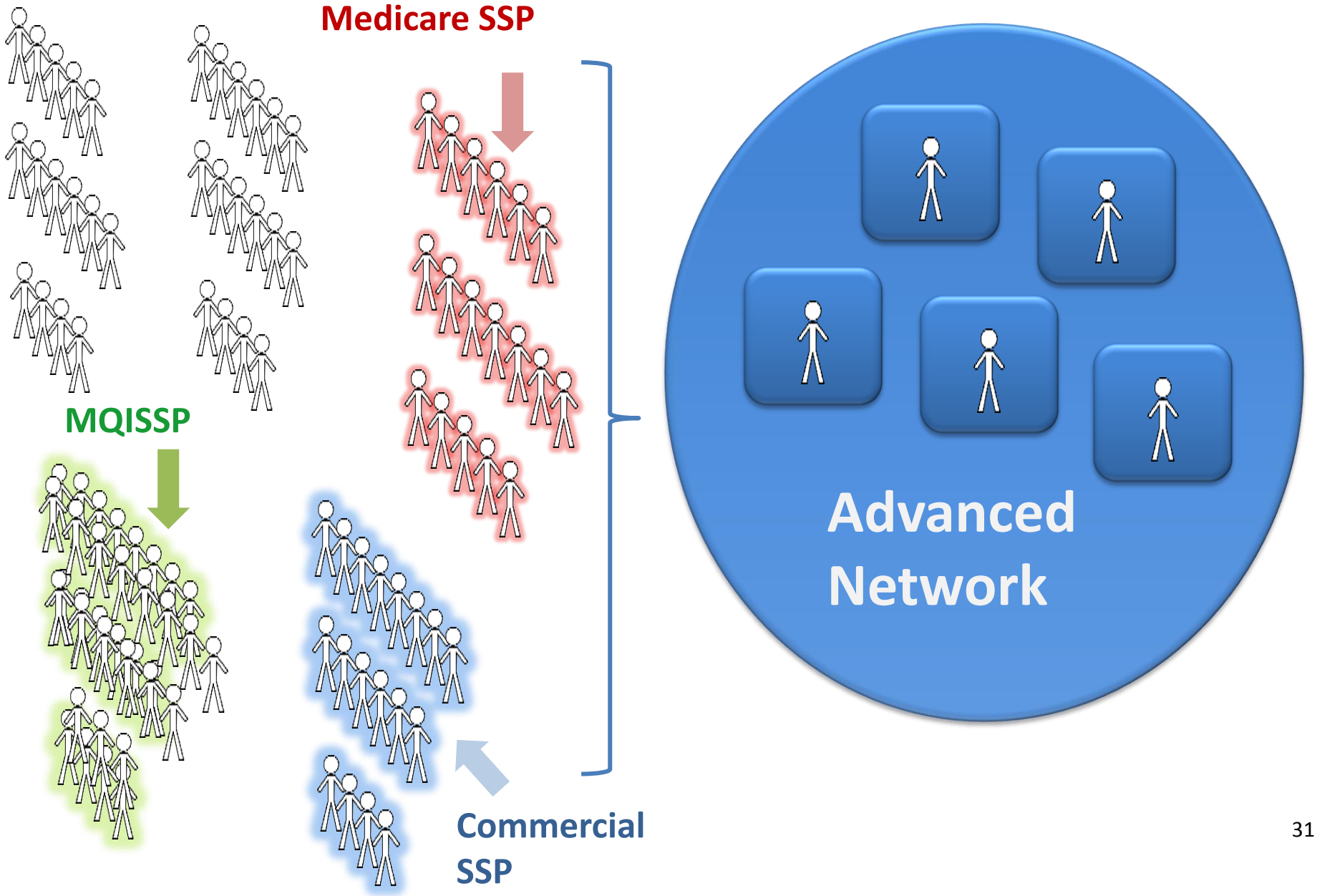
Value Based Payment

$$\text{Value} = \frac{\text{Quality \& Care Experience}}{\text{Total Cost of Care}}$$

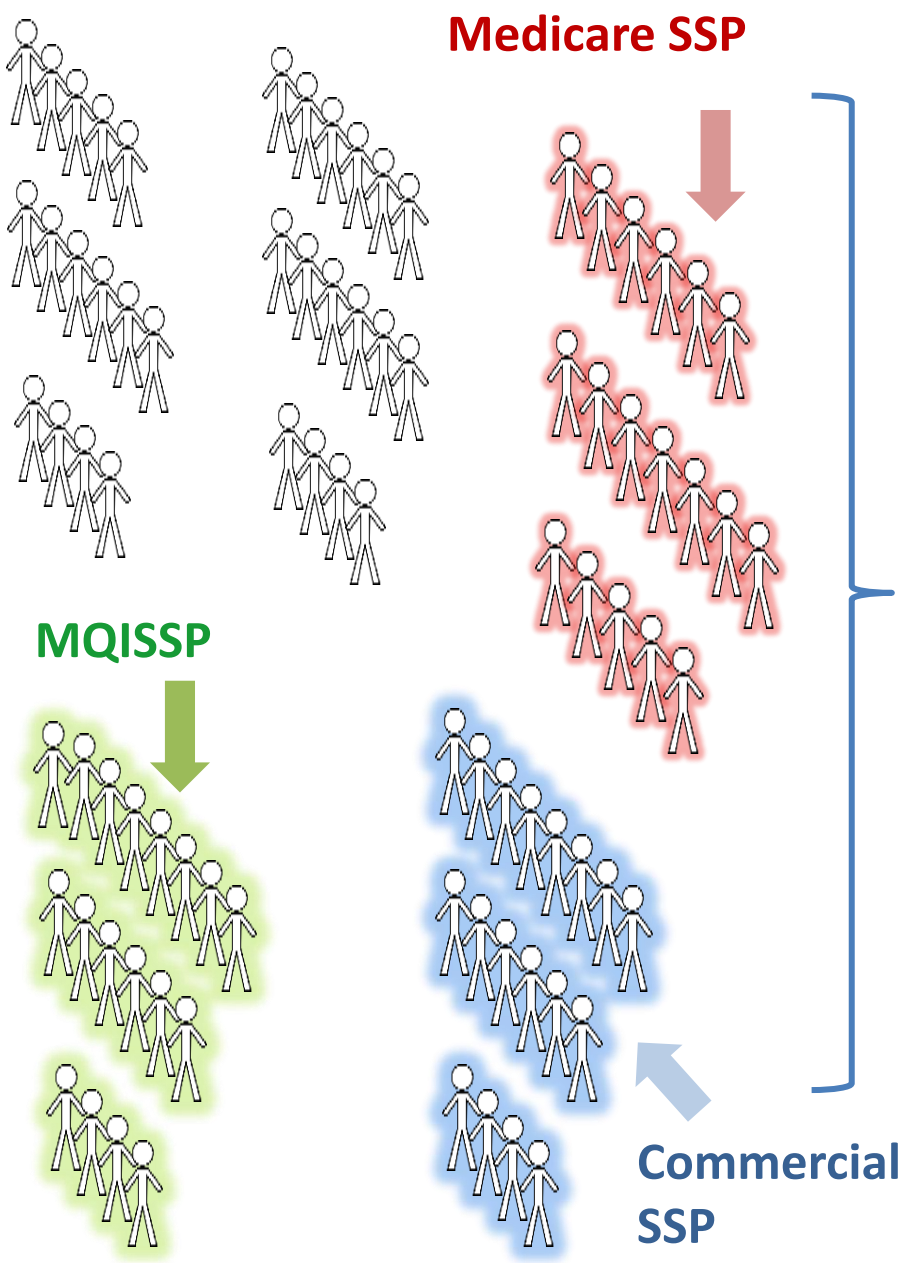
Expanding the reach of Value Based Payment

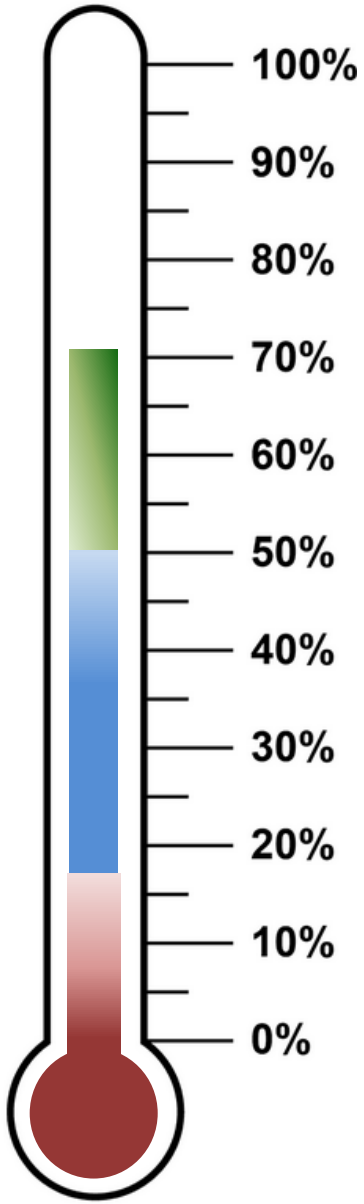


Expanding the reach of Value-Based Payment



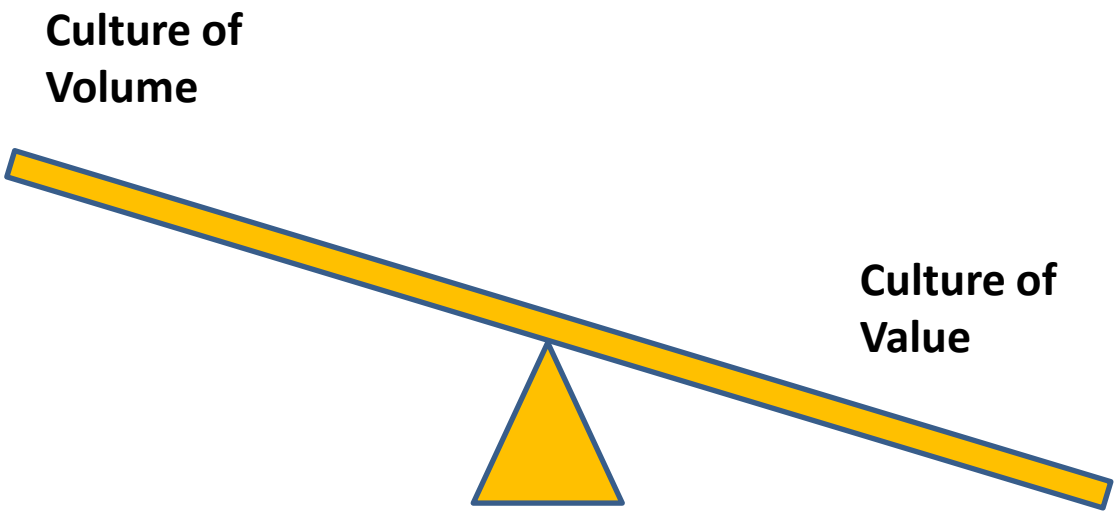
Reaching the tipping point

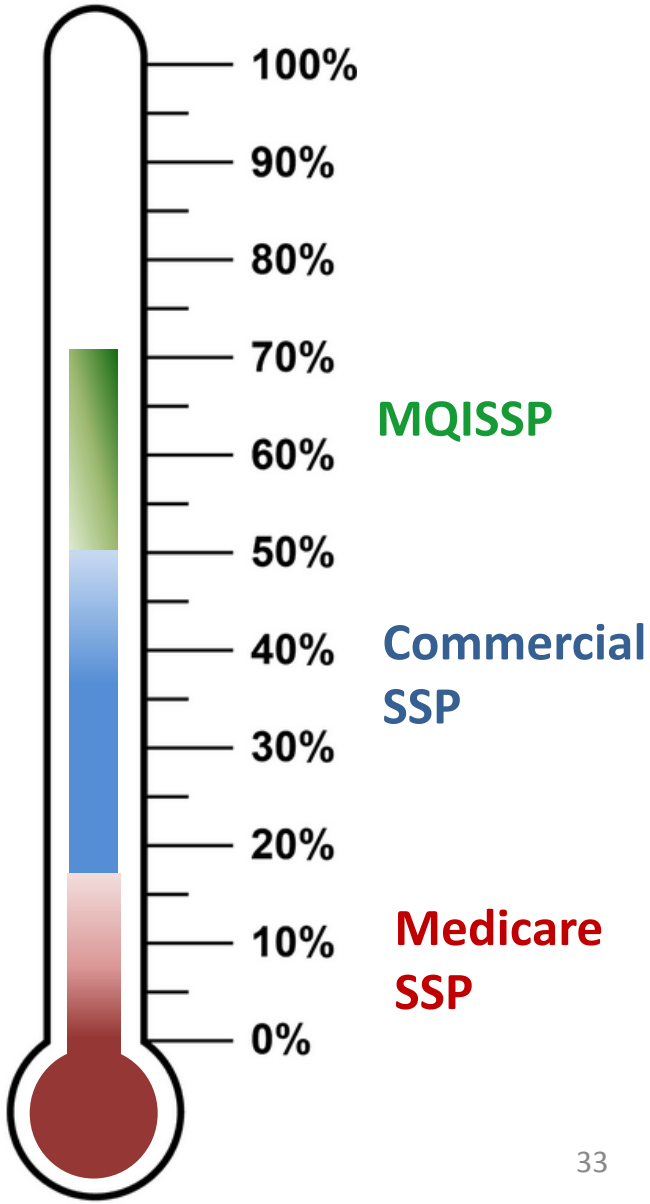




% of consumers in an Advanced Network in value-based payment arrangement

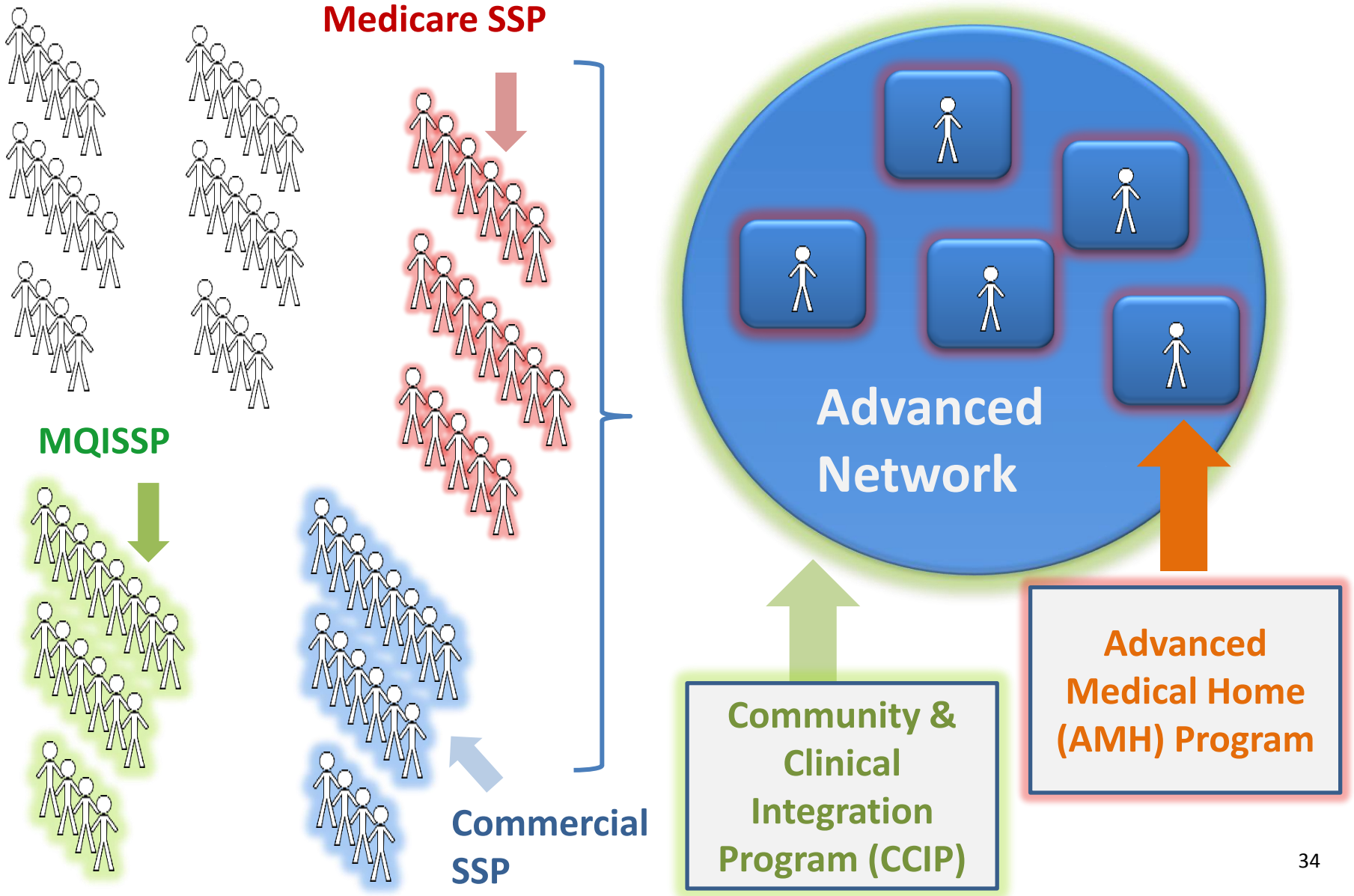
Reaching the tipping point





% of consumers in an Advanced Network in value-based payment arrangement

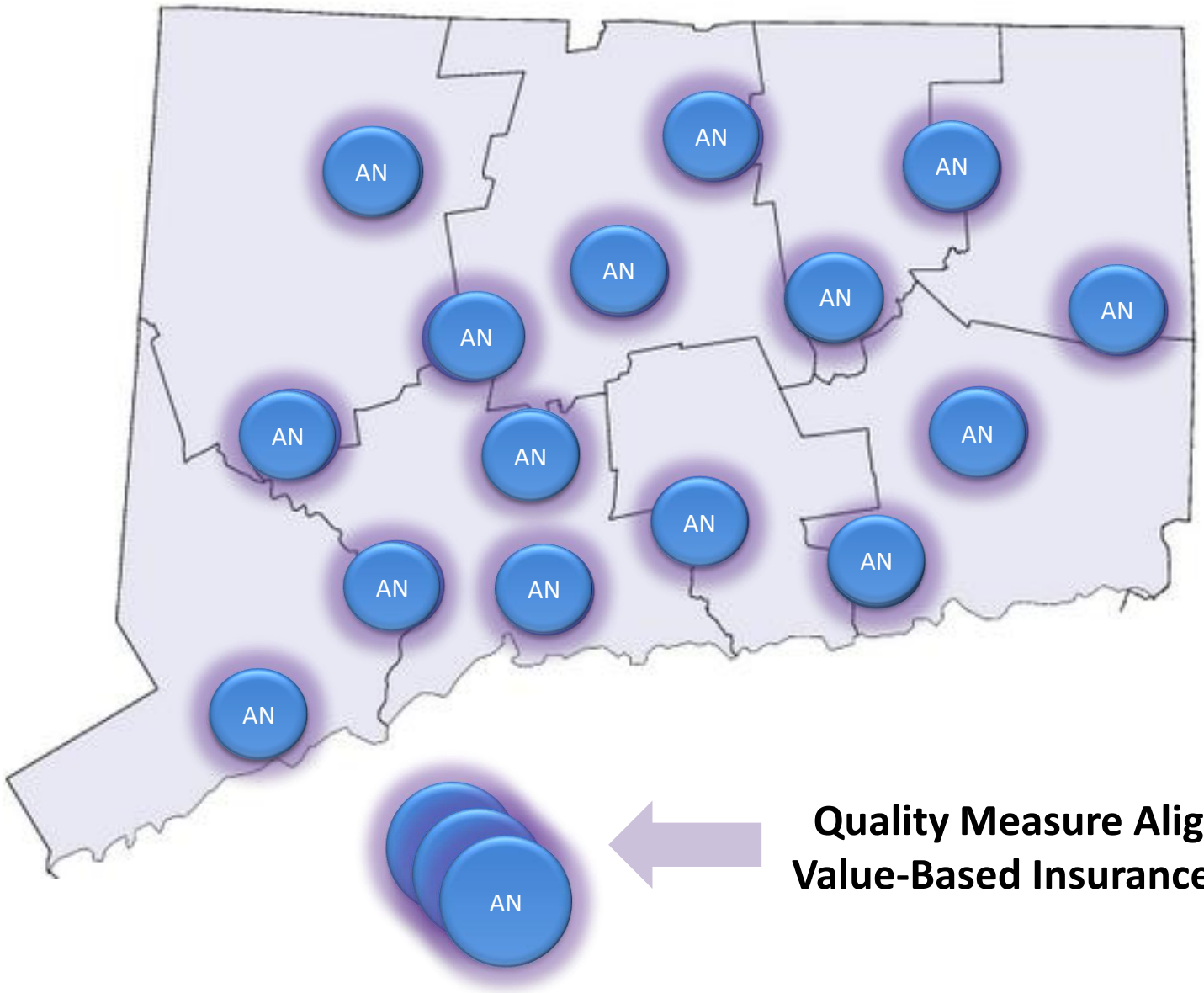
Putting it all together



Targeted Initiatives

Statewide Initiatives

Statewide Initiatives



Quality Measure Alignment
Value-Based Insurance Design

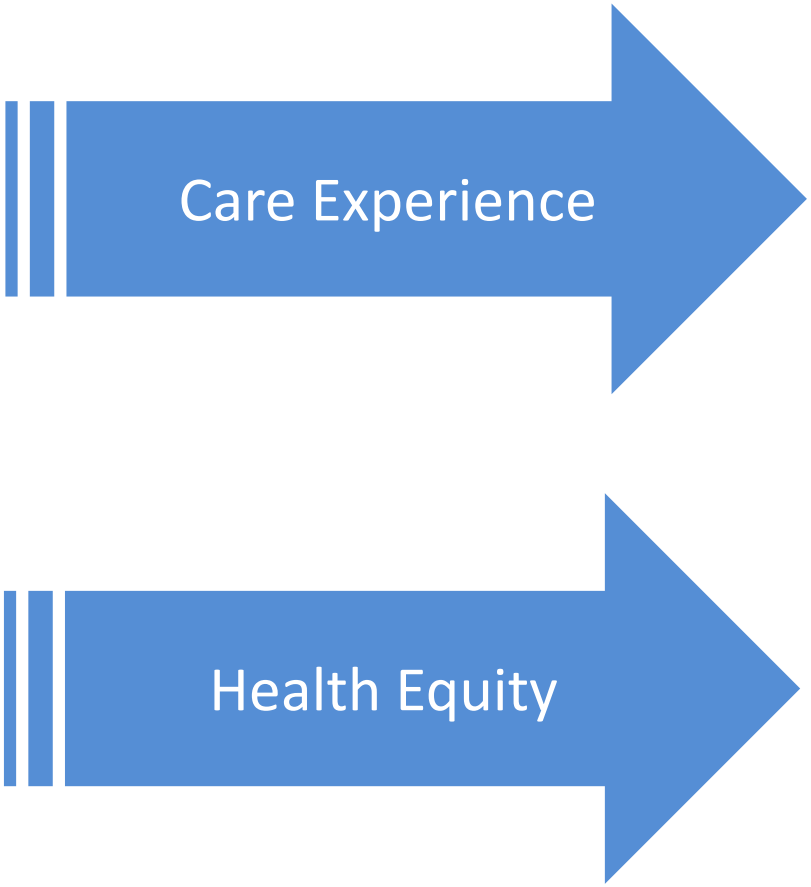
Quality Measure Alignment

Quality Measure Alignment

Goals outlined in the test grant:

1. Core quality measurement set for primary care, select specialists, and hospitals
2. Common cross-payer measure of care experience tied to value based payment
3. Common provider scorecard

Core Measure Set



Provisional Core Quality Measure Set 10-6-15

Consumer Experience Measure	NQF	ACO
PCMH – CAHPS measure	0005	

Care coordination/patient safety	NQF	ACO
Plan all-cause readmission	1768	
All-cause unplanned admissions for patients with DM		36
Asthma in younger adults admission rate	0283	
Asthma admission rate(child)	0728	
Emergency Department Usage per 1000		
Documentation of current medications in the medical record	0419	39
Annual monitoring for persistent medications (roll-up)	2371	
Adult major depressive disorder (MDD): Coordination of care of patients with specific co-morbid conditions		

Prevention Measure	NQF	ACO
Breast cancer screening	2372	20
Cervical cancer screening	0032	
Chlamydia screening in women	0033	
Colorectal cancer screening	0034	19
Adolescent female immunizations HPV	1959	
Weight assessment and counseling for nutrition and physical activity for children/adolescents	0024	
Preventative care and screening: BMI screening and follow up	0421	16
Developmental screening in the first three years of life	1448	
Well-child visits in the first 15 months of life	1392	
Well-child visits in the third, fourth, fifth and sixth years of life	1516	
Adolescent well-care visits		
Tobacco use screening and cessation intervention *Prenatal Care & Postpartum care*	0028 1517	17
Frequency of Ongoing Prenatal Care (FPC)	1391	
Oral health: Primary Caries Prevention	~~1419~~	
Screening for clinical depression and follow-up plan	0418	18
Oral Evaluation, Dental Services (Medicaid only)	2517	
Behavioral health screening (pediatric, Medicaid only, custom measure)		

Acute & Chronic Care Measure	NQF	ACO
Medication management for people with asthma	1799	
Asthma Medication Ratio	1800	
DM: Hemoglobin A1c Poor Control (>9%)	0059	27
DM: HbA1c Screening (interim measure until NQF 0059 is stood up)	0057	
DM: Diabetes eye exam	0055	41
DM: Diabetes foot exam	0056	
DM: Diabetes: medical attention for nephropathy	0062	
HTN: Controlling high blood pressure Use of imaging studies for low back pain	0018 0052	28
Avoidance of antibiotic treatment in adults with acute bronchitis	0058	
Appr. treatment for children with upper respiratory infection *Cardiac strss img: Testing in asymptomatic low risk patients*	0069 0672	

Behavioral Health Measure	NQF	ACO
Follow-up care for children prescribed ADHD medication	0108	
Metabolic Monitoring for Children and Adolescents on Antipsychotics (pediatric, Medicaid only, custom measure)		
Depression Remission at 12 Twelve Months	0710	40
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	1365	
Unhealthy Alcohol Use – Screening		

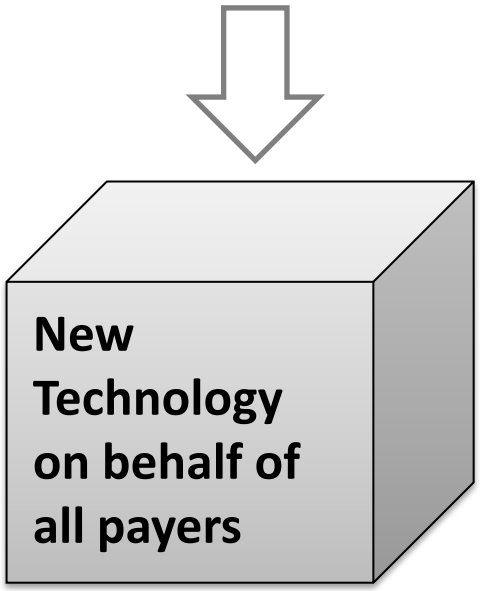
Core Measure Set

Payers currently produce claims based measure

State proposes to produce

- **EHR based measures**
- **Care experience survey measures**

SIM Funded HIT



EHR measure production

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Unhealthy Alcohol Use – Screening		

Core Measure Set – Preventive Health

	Preventive Health Measures	NQF
1	Breast Cancer Screening	2372
2	Cervical Cancer Screening	32
3	Chlamydia Screening in Women	33
4	Adolescent female immunizations HPV	1959
5	Prenatal and postpartum care	1517

Provisional Reporting Measure Set – Behavioral Health

Reporting Measures		NQF
1	Frequency of On-going Prenatal Care	1391

Quality Measure Alignment

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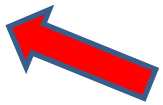
1. Core quality measurement set for primary care, select specialists, and hospitals
2. Common cross-payer measure of care experience tied to value based payment
3. Common provider scorecard?

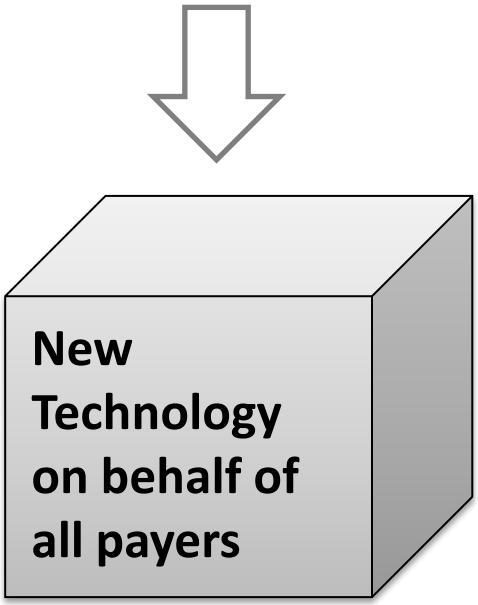


Future focus of Quality Council

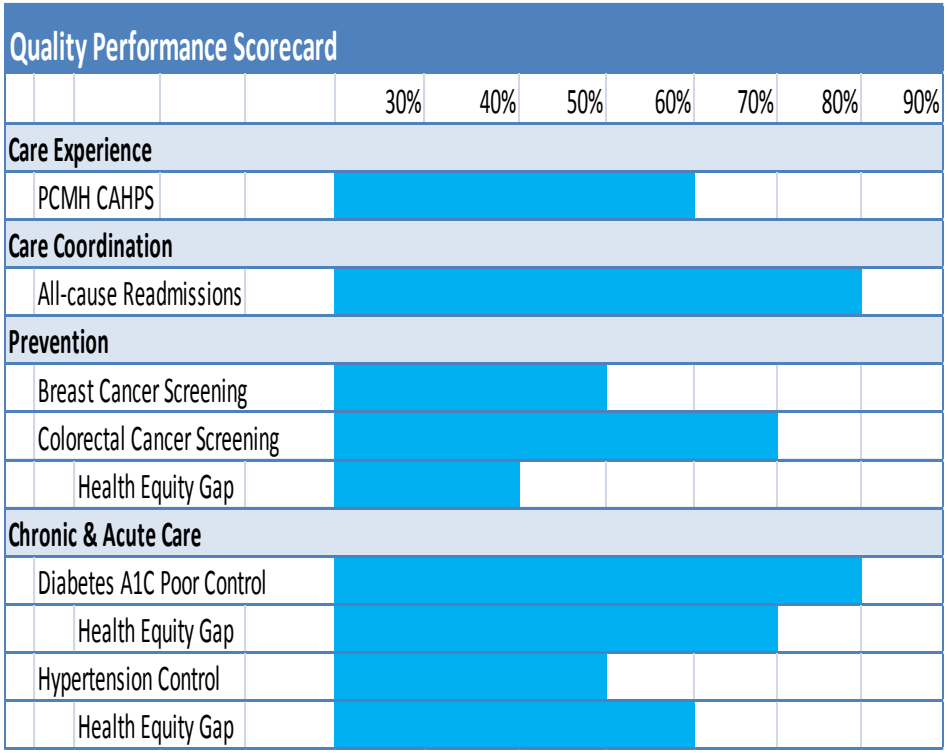
Common Scorecard?

Payer agnostic scorecard for public reporting

SIM Funded HIT?



Claims and EHR Data?



APCD?

Value-based Insurance Design

Value-based Insurance Design

...the use of plan incentives to encourage employee adoption of one or more of the following:

New and innovative approaches

Adopt healthy lifestyles
(e.g. smoking cessation, physical activity)

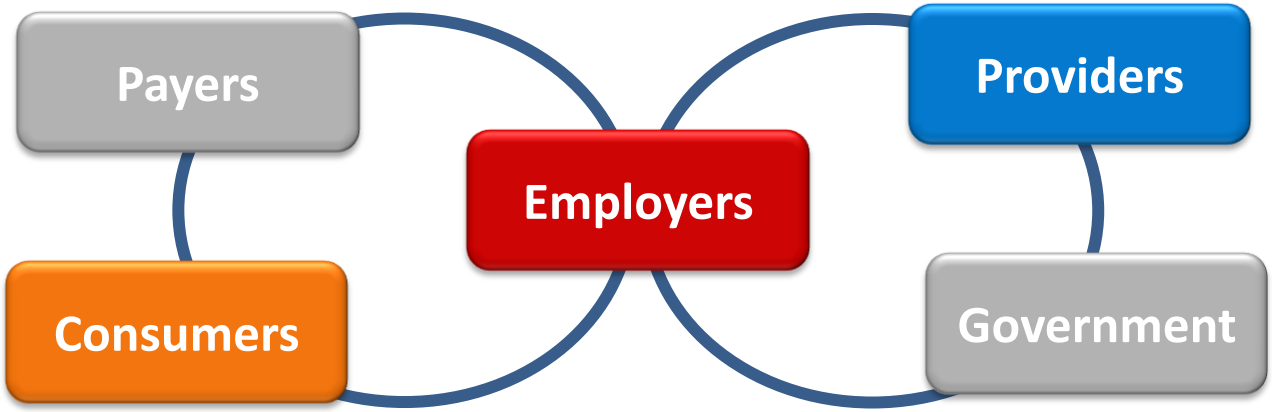
Use high value services
(e.g., preventative services, certain prescription drugs)

Use high performance providers
Who adhere to evidence-based treatment

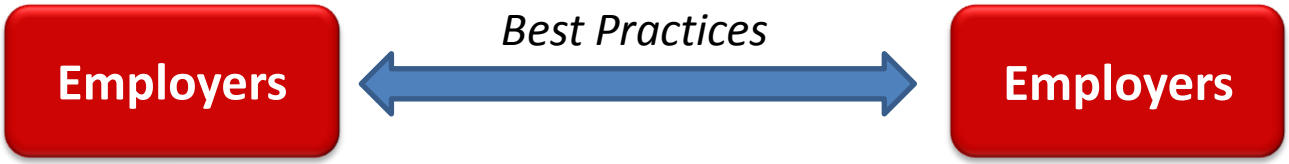
- **Health promotion & disease management**
- **Health coaching & treatment support**

Program Goals

1. Develop prototype VBID plan designs that align the interests of consumers and providers



2. Provide a mechanism for employers to share best practices to accelerate the adoption of VBID plans



Key Partners

CBIA
CONNECTICUT BUSINESS & INDUSTRY ASSOCIATION

NORTHEAST BUSINESS GROUP ON HEALTH

CONNECTICUT BUSINESS GROUP ON HEALTH
Promoting a better healthcare delivery system

STATE OF CONNECTICUT
QUI TRANSTULIT SUSTINET
COMPTROLLER'S OFFICE

Office of the State Comptroller (state employee health plan)

SIM VBID Components

- **Employer-led Consortium**: peer-to-peer sharing of best practices

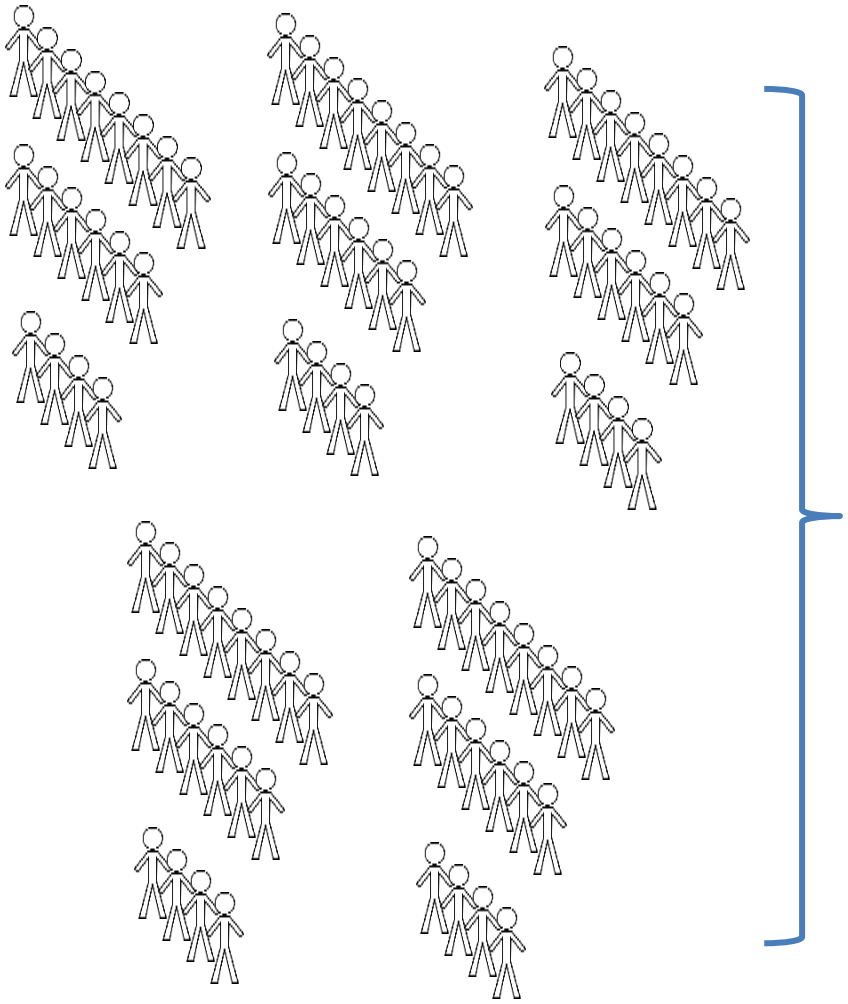
- **Prototype VBID Designs**: using latest evidence, to make it easy for employers to implement

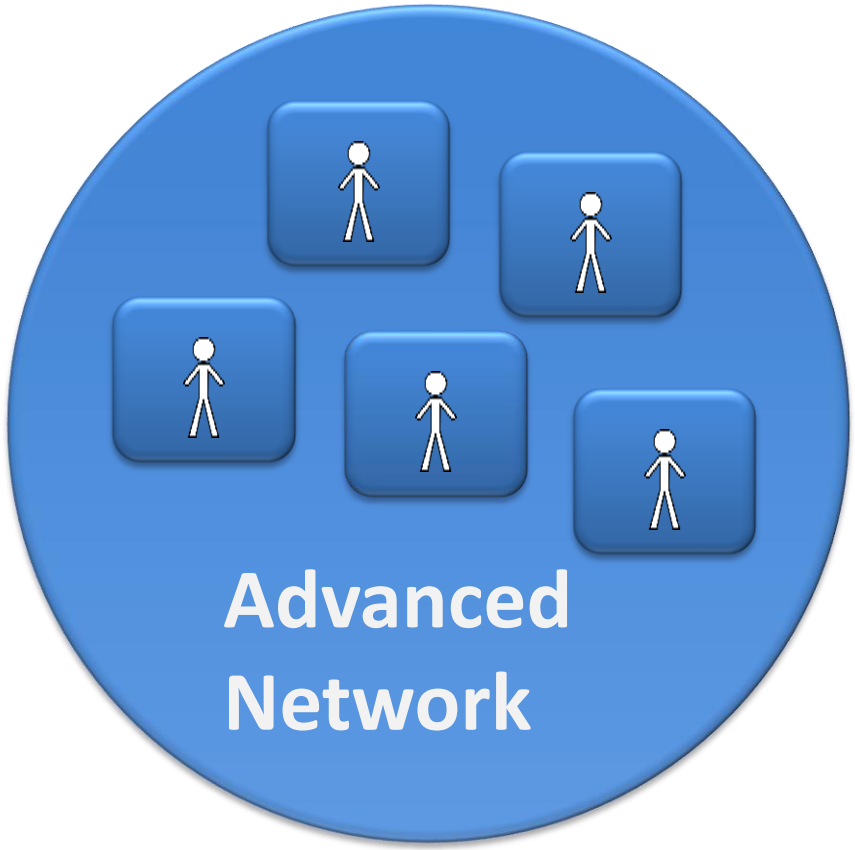
- **Annual Learning Collaborative**: including panel discussions with nationally recognized experts and technical assistance

access health CT
Connecticut's Health Insurance Marketplace

CT's Health Insurance Market Exchange) will implement VBID in Year 2 of the Model Test (subject to Board approval)

Aligning strategies to engage consumers and providers





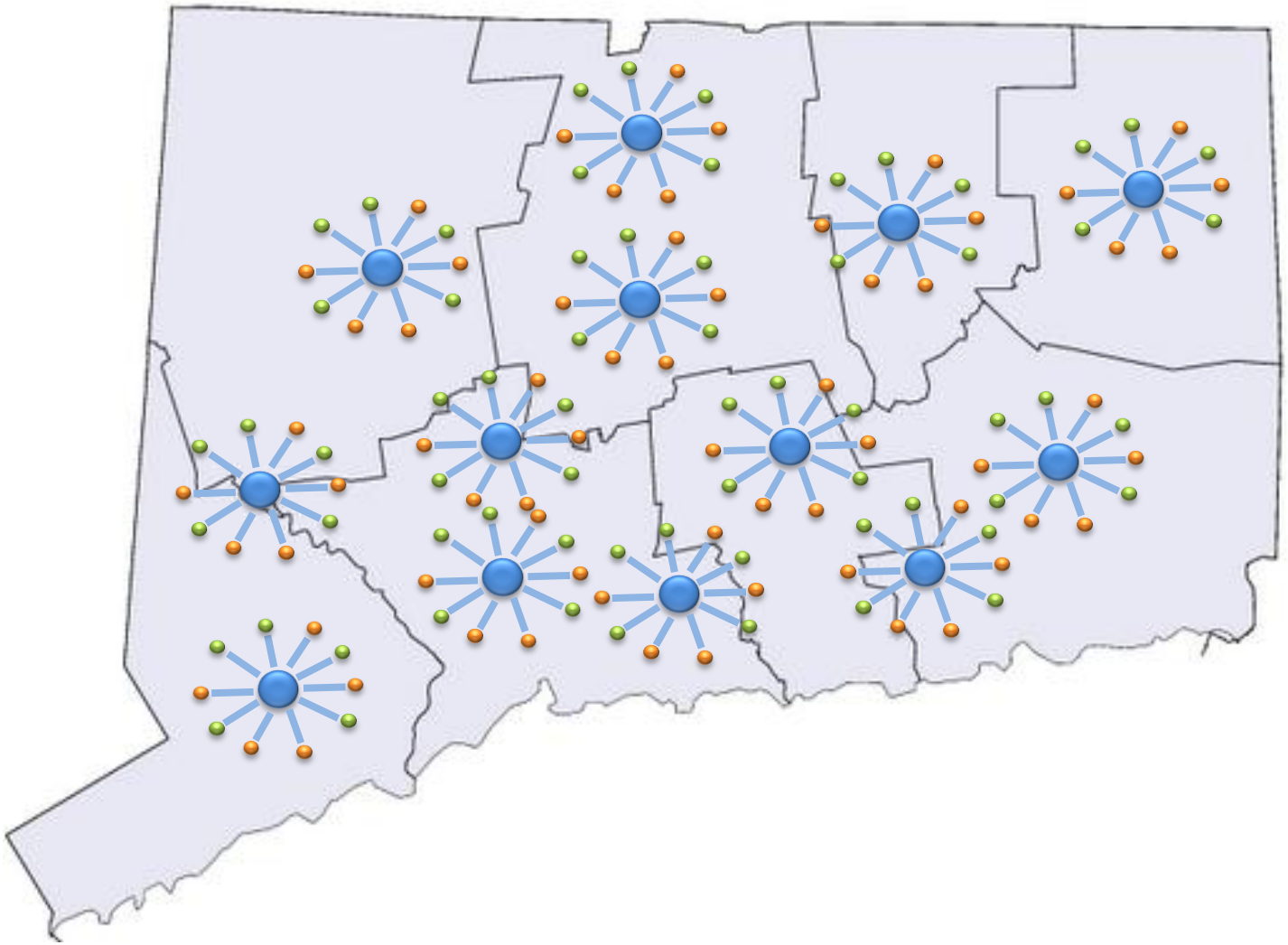
Value-based Insurance Design

Value-based Payment

Health Enhancement Communities 3.0

Community and clinically integrated

throughout Connecticut



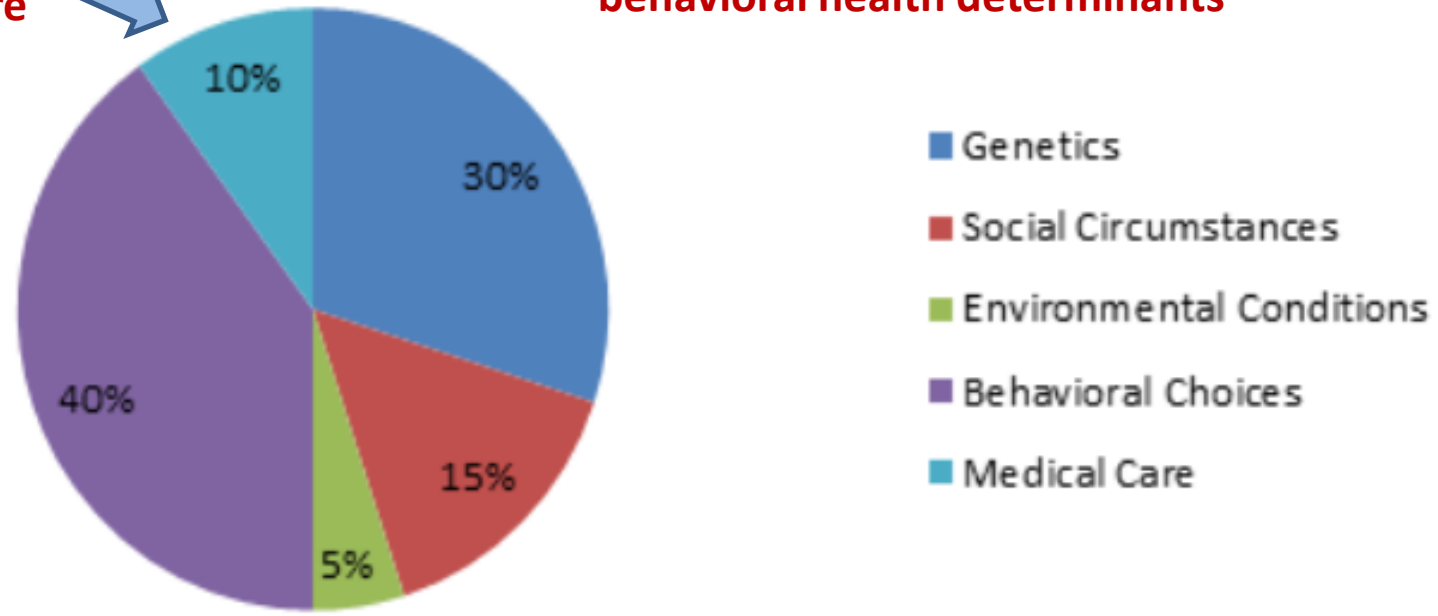
ACO accountability rewards better healthcare…

but it does not reward better health

Health determinants that affect mortality

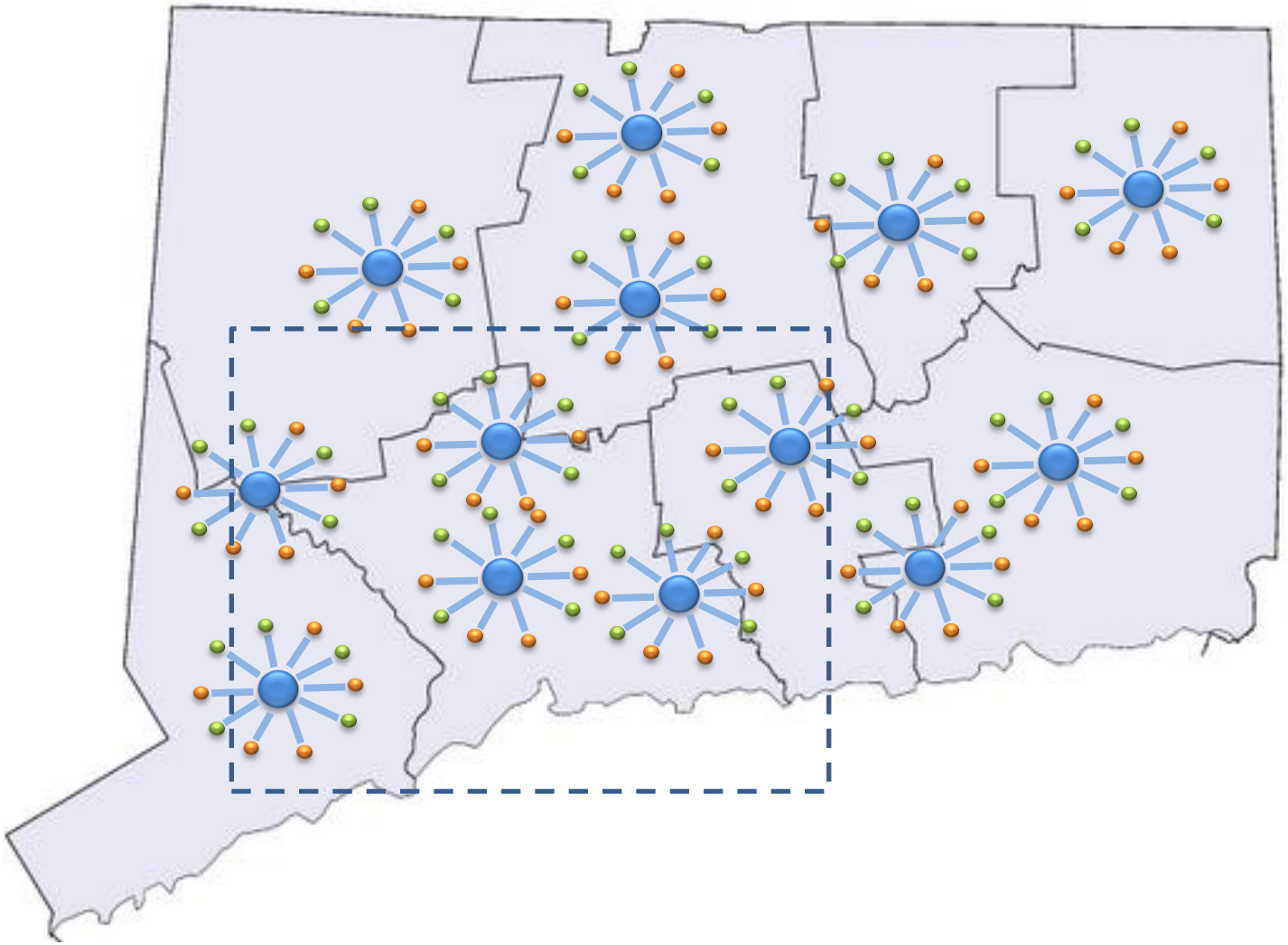
10% is healthcare

60% is social, environmental and behavioral health determinants



Taking aim at the determinants of health requires…

a regional focus

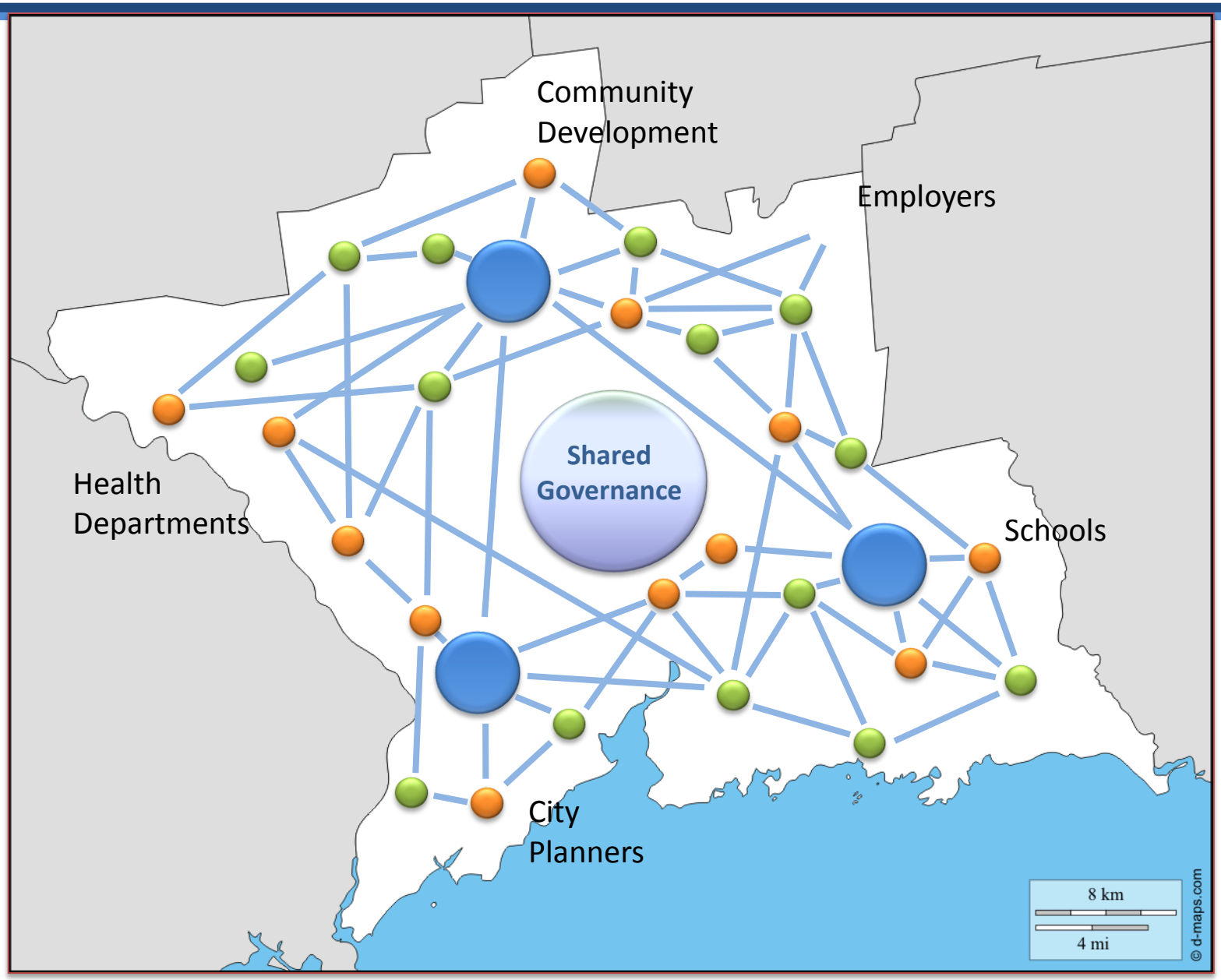


Expand linkages among community stakeholders…

building upon those that already exist

- Relationships among ACOs and all community stakeholders
- Accountability for the health and well-being of all community residents

A pathway to community accountability



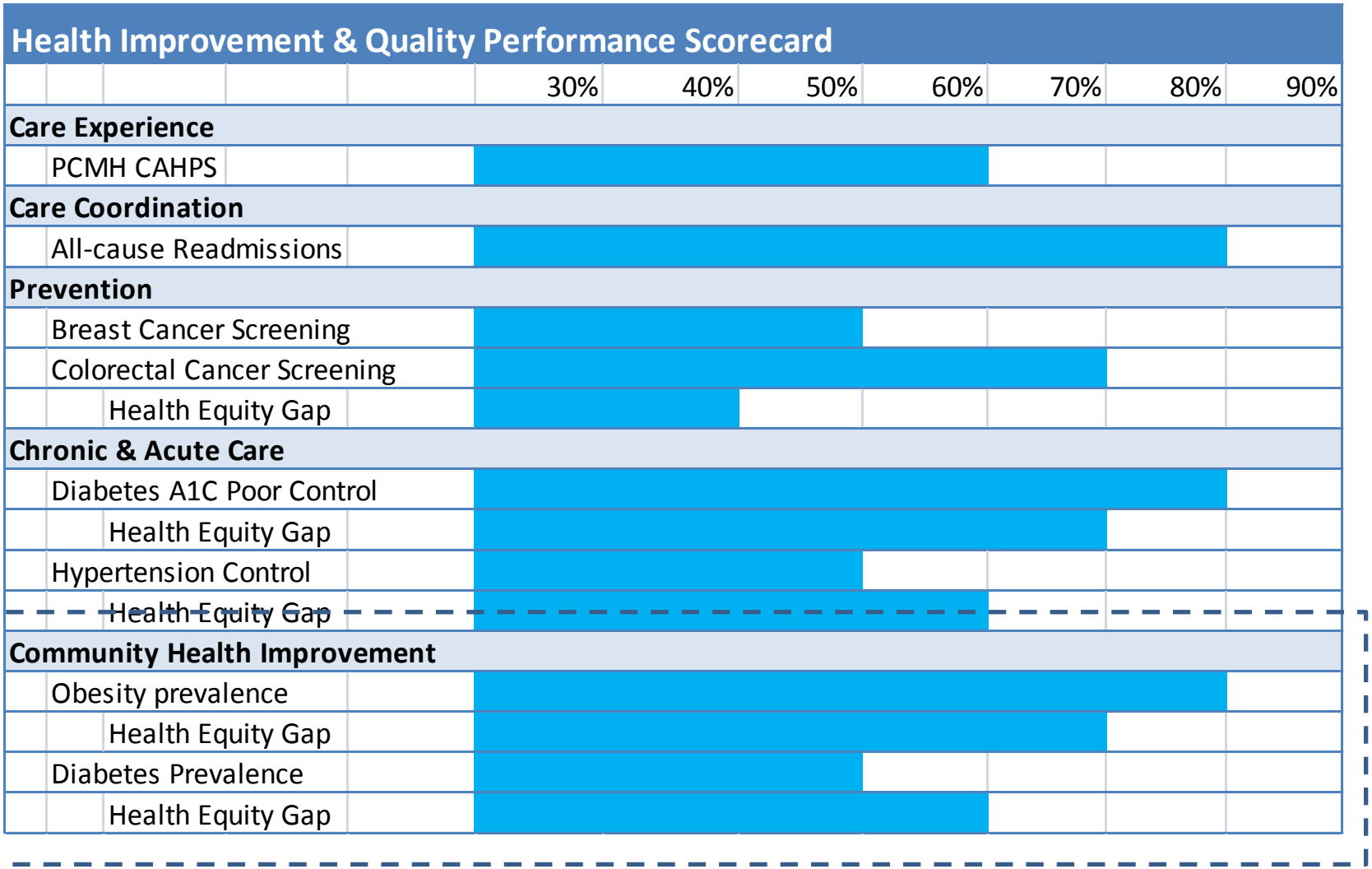
Example only: actual regions may be smaller and/or have different boundaries

Accountability for…

- All residents of the community
- Performance
  - improving community health (i.e., prevention outcomes)
  - improving health equity
  - lowering the cost of healthcare and the cost of poor health

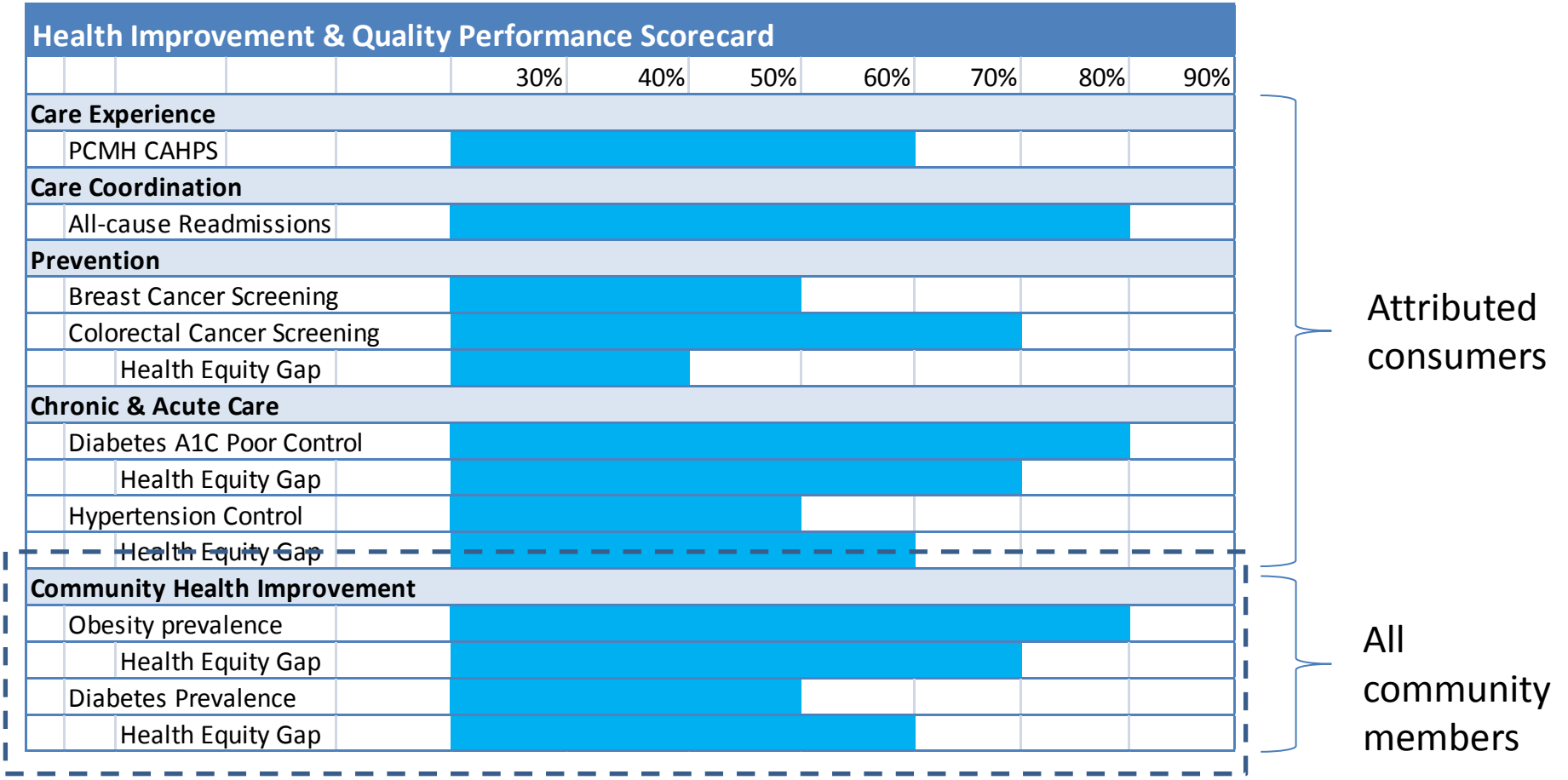
Rewards for ACOs that play a role in producing…

measurable improvement in community health



Rewards for ACOs that play a role in producing…

measurable improvement in community health

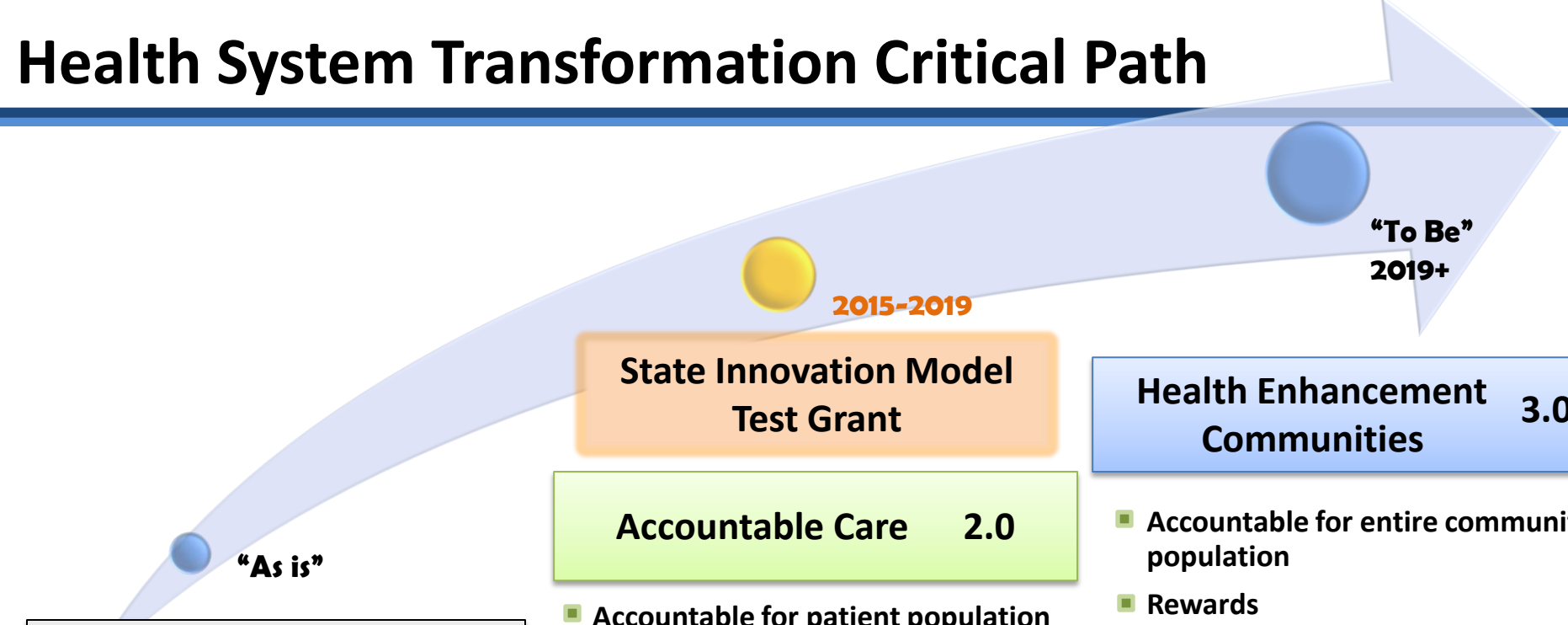


Rewards for community participants…

through new vehicles for reinvestment

- Wellness trust?
- Community stakeholder distributions?
- Consumer incentives?
- Targeted investments…for example
  - Access to healthy food
  - Enhanced walkability
  - Opportunities for an active lifestyle
  - Improvements in housing stock

Health System Transformation Critical Path



"As is"

Fee for Service 1.0

- Volume-based
- Poorly coordinated
- No quality & cost transparency
- Unsustainable healthcare costs
- Limited data infrastructure
- Persistent health disparities
- Uninformed consumers

2015-2019

State Innovation Model Test Grant

Accountable Care 2.0

- Accountable for patient population
- Rewards
  - Better health outcomes
  - Preventive care processes
  - Lower cost of healthcare
- Competition on healthcare outcomes, experience & cost
- Coordination of care across medical neighborhood
- Community integration to address social-demographic factors that affect outcomes

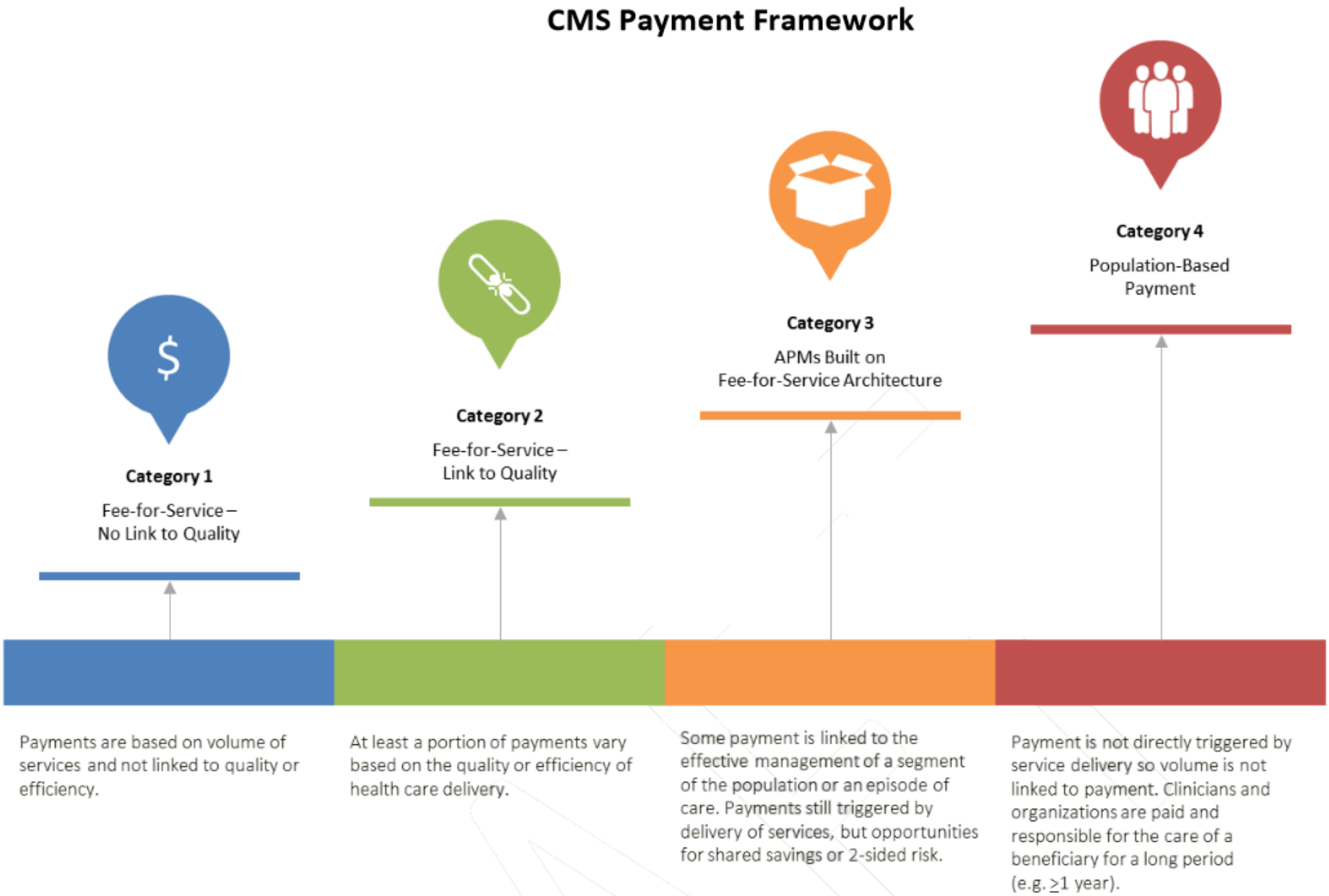
"To Be"
2019+

Health Enhancement Communities 3.0

- Accountable for entire community population
- Rewards
  - Prevention outcomes
  - Lower cost of healthcare & health
- Cooperation to reduce risk and improve health
- Shared governance including ACOs, employers, non-profits, schools, health departments and municipalities
- Community initiatives to address social-demographic factors that affect health

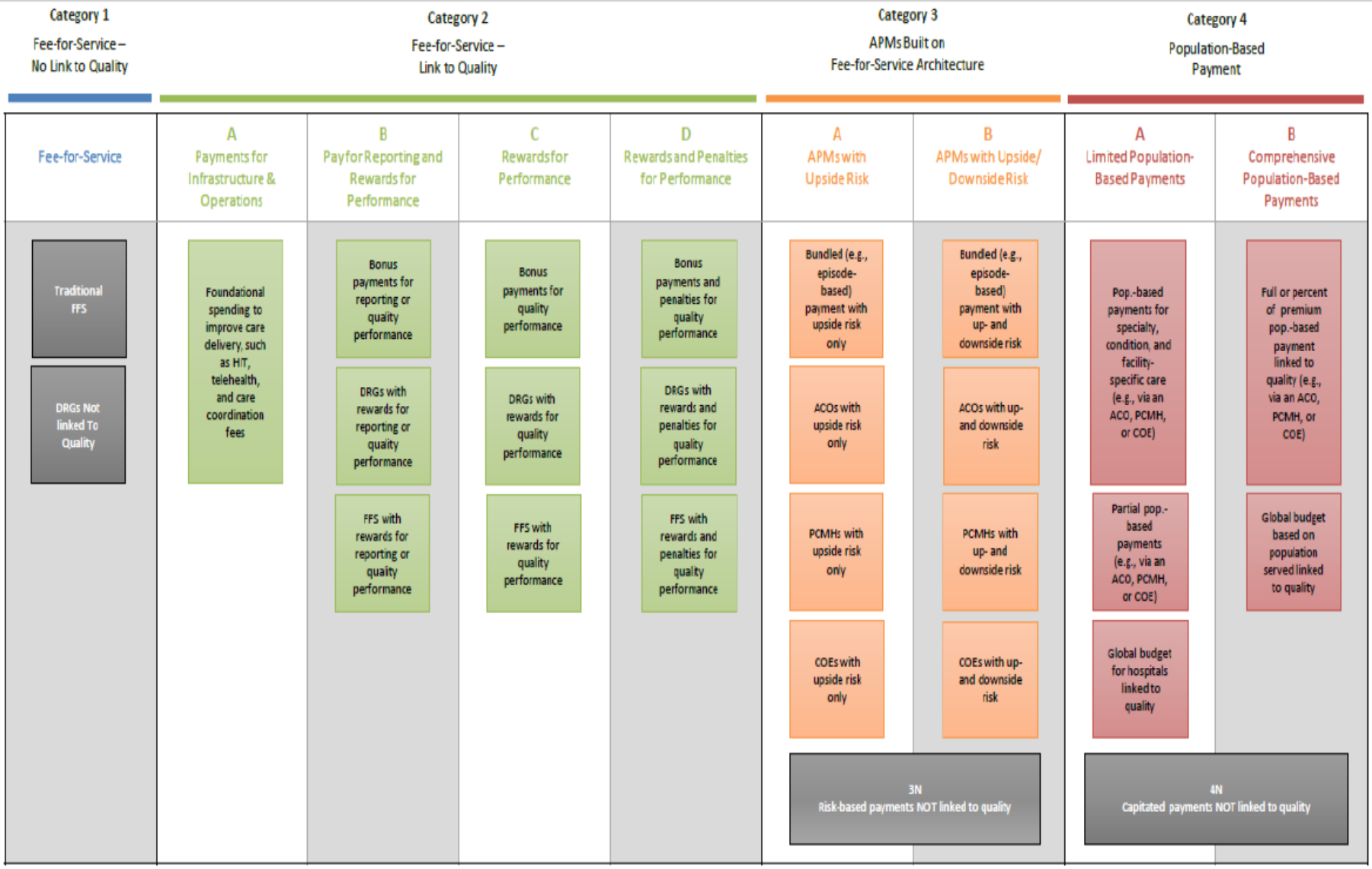
HCPLAN

What is an Alternative Payment Model (APM)?



HCP LAN APM Framework

Draft LAN Framework



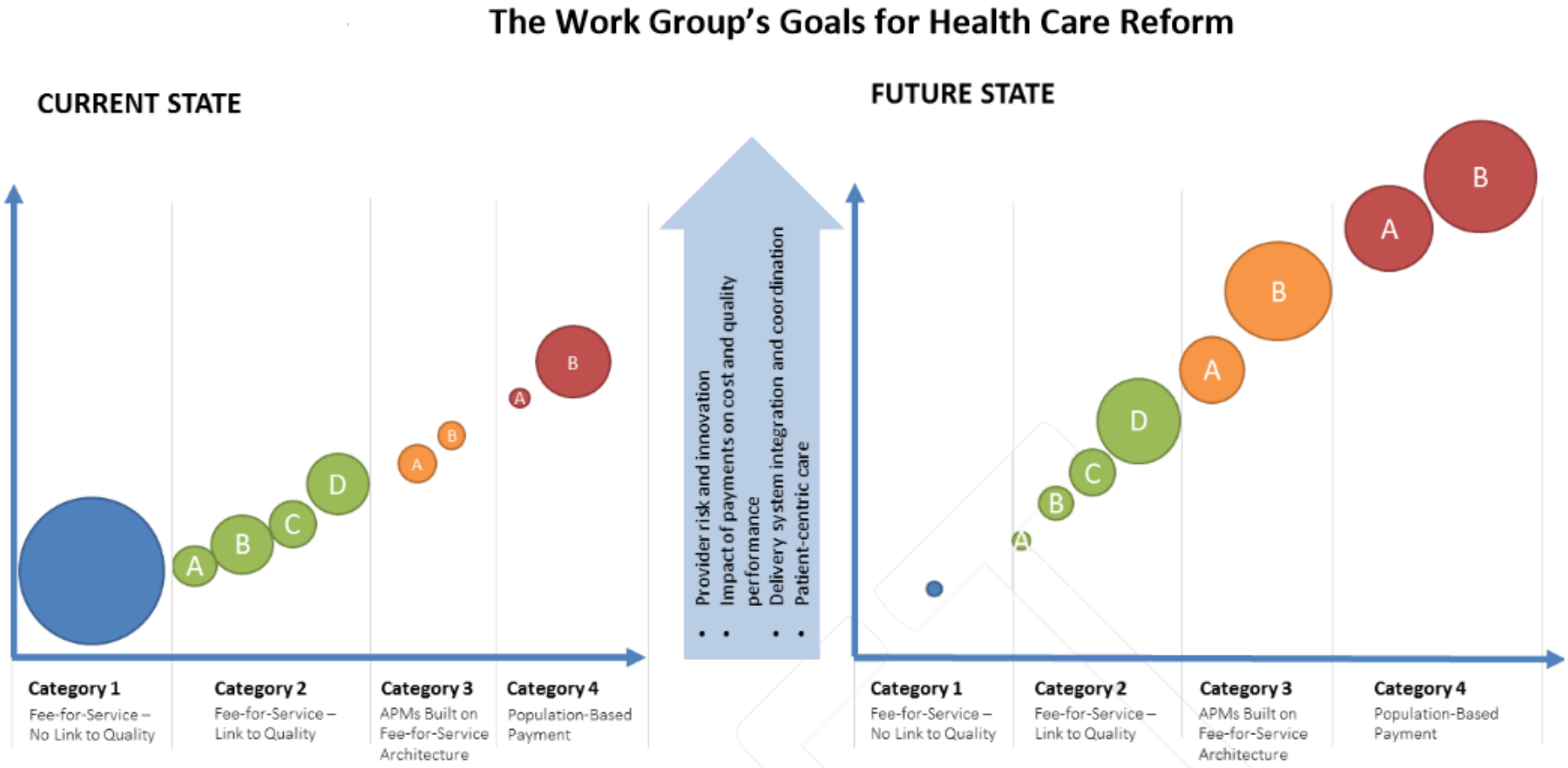
Alternative Payment Framework

CMS has adopted a framework that categorizes payments to providers

Historical state → Evolving future state

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	▪ Payments are based on volume of services and not linked to quality or efficiency	▪ At least a portion of payments vary based on the quality or efficiency of health care delivery	▪ Some payment is linked to the effective management of a population or an episode of care ▪ Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	▪ Payment is not directly triggered by service delivery so volume is not linked to payment ▪ Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)
Medicare Fee-for-Service examples	▪ Limited in Medicare fee-for-service ▪ Majority of Medicare payments now are linked to quality	▪ Hospital value-based purchasing ▪ Physician Value Modifier ▪ Readmissions / Hospital Acquired Condition Reduction Program	▪ Accountable Care Organizations ▪ Medical homes ▪ Bundled payments ▪ Comprehensive Primary Care initiative ▪ Comprehensive ESRD ▪ Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	▪ Eligible Pioneer Accountable Care Organizations in years 3-5 ▪ Maryland hospitals

Future State of APM Adoption



The overarching objective of the LAN is to encourage alignment between and within the public and private sectors as the health care system moves away from traditional fee-for-service payment. The LAN recommends that, over time, public and private health plans should move concertedly towards **APMs in Categories 3 and 4**, to achieve the goals of healthier people, improved care, and reduced cost

Questions